



Part 1

Intermediate Care







Chapter 1

Intermediate Care: Policy and Context

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Introduction

The term 'intermediate care', as applied to elements of the British health and social care systems, emerged in the mid-1990s. Initially ambiguous, with its origins predating adoption as formal government policy, it was first recognised officially in the National Beds Inquiry consultation document (Department of Health, 2000a). Department of Health policy on this subject is now contained in the 2001 Health and Local Authority circular, HSC 2001/01: LAC (2001)1 (Department of Health, 2001a) and in Standard 3 of the *National Service Framework for Older People* (Department of Health, 2001b).

What is intermediate care? Its short history is peppered with attempted definitions, reflecting the evolutionary process by which the services now bearing this description have developed over recent years. Some essential common elements have emerged: these services are locally based, providing 'care closer to home' (Department of Health, 2000a, p. 13); they are focused on maintaining or restoring independence and are rehabilitative in nature; they are of short term duration. A key feature is the multiprofessional nature of the delivery teams, which are drawn from both health and social care. For the sake of clarity, a more comprehensive definition is attempted here:

'Intermediate care, when fully developed, comprises networks of local health and social care services, which deliver targeted, short term support to individual patients or clients, in order to prevent inappropriate admission to NHS acute inpatient or continuing care, or long-term residential care, facilitate earlier discharge from hospital and, most importantly, maximise people's ability to live independently within their communities.'

At present, most intermediate care services are focused on providing support for older people and will generally be provided in service users' own homes, or in community based settings, although, in some instances, they may be provided in discrete facilities on acute hospital sites. 'Social care' is provided by statutory,



voluntary and independent agencies and also local authority housing departments.

The growth of intermediate care since the mid-1990s is a fascinating example of a grassroots response to local service pressures (albeit within a developing national 'consciousness'), which has dramatically influenced the direction of Government policy. However, its early history, one of local initiatives, usually small scale and established on short-term funding (and thus lacking stability), has resulted in a wide diversity of models: 'a thousand flowers have bloomed' (Department of Health, 2002b, p. 5). There has been no consistent approach across the country; while local initiative has been a strength, the proliferation of schemes has also led, in some areas, 'to confusion and fragmentation, in turn resulting in inequality of provision and access, duplication of effort, reduced cost effectiveness, and loss of impact' (Department of Health, 2002b, p. 5). In addition, until recently, there has been little robust evaluation of the effectiveness of intermediate care, and therefore no real guidance for investment decisions.

In this chapter the following themes are explored:

- The context within which intermediate care has evolved.
- The development of government policy on the subject.
- Some of the key policy and implementation issues which require resolution in order to embed intermediate care firmly into mainstream services.

Context

Whilst the term 'intermediate care' is relatively new, the underlying concept of inter-agency cooperation to maximise independent living, particularly for older people, clearly is not. Indeed, as Swift has recently argued in his article on the *National Service Framework for Older People*, 'in successful departments (providing specialist medical care for older people) excellent partnerships with other agencies (particularly primary and social care) and with other specialties have been axiomatic' (Swift, 2002). That being the case, why has there been such interest in 'intermediate care' in recent years?

The answer to this question lies in the complex interaction of a number of contextual factors, which coalesced in the 1990s to create a health and social care climate where increased demand, and changes in supply, produced service pressures which, allied with financial incentives, led to a search for alternative delivery methods, both at a local and national, level which made more intensive and appropriate use of health and social care resources. Thus, while local communities explored the potential benefits which a closer partnership between health and social care might bring, particularly at the interface between acute hospital care and community NHS and social care, at a Governmental level there was a developing interest in international experience of alternative systems, which also coincided with a greater focus on individual patient care. These contextual factors are examined in more detail below.



Changes in demand

A number of factors fuelled an increase in demand for health and social care services in the late 20th century. These included demographic trends, technical advances, and consumer awareness and expectations.

Demographic trends

In the latter years of the 20th century, demographic trends were continuing to change the underlying structure of the UK population. Between 1981 and 1997, total population increased by just 5%; interestingly, there was a drop in those aged between 65 and 74 but, and notably, those aged between 75 and 84 increased by 18% and those over 85 increased by 80% (Audit Commission, 1997). In addition, recent estimates have predicted that, from the mid-1990s, the number of people in England aged 65 and over will rise by almost 57% until the third decade of the 21st century and the number of people over 85 will rise by 79% over the same period (Vaughan and Lathlean, 1999). These trends have significant resource implications for both the health and social care sectors, since, as is well known, older people are major consumers of these services.

In its 1997 publication *The Coming of Age: Improving Care Services for Older People*, the Audit Commission noted that, while those over 65 constituted 14% of the population, they accounted for 47% of Department of Health expenditure and 48% of local authority social services expenditure (Audit Commission, 1997). In 2000, the National Beds Inquiry found that people aged over 65 occupied two-thirds of general and acute hospital beds and accounted for over half the recent growth in emergency admissions (Department of Health, 2000a). In addition to increased pressure on acute services, older people tend to recover more slowly than younger people and this places more pressure on both transitional and social care services.

Technical advances

In addition to demographic changes, technical advances in the late 20th century created a greater demand for chronic care support. These advances improved life expectancy generally, but also enabled people with serious disabilities to extend their lifespan. They also allowed more intensive therapies to be delivered at home, making home based care options feasible.

Increasing consumer awareness and expectations

Increasing consumer awareness, knowledge and expectations have created a demand for better rehabilitation services. Consumers also have a natural preference to be at home rather than in hospital or institutional residential care. As Steiner has noted, one of the attractions of intermediate care is that it 'focuses on the transition away from the status of "patient" towards the restoration of "person"' (Steiner, 1997, p. 5).



Changes in supply

Within the NHS, the second half of the 20th century saw a dramatic reduction in the number of NHS staffed beds for acute, general and maternity care, which peaked at around 250 000 in 1960 but had reduced to 147 000 by the end of the 1990s (Department of Health, 2000a). In addition, and particularly relevant to this debate, geriatric bed numbers fell from 56 000 to 30 000 over the same period (Vaughan and Lathlean, 1999). This trend was taking place at the same time as an increase in general hospital admissions and particularly admissions of older people: the National Beds Inquiry found that 'year on year, there has been continuous growth in the proportion of older people requiring overnight stays in hospital' (Department of Health, 2000a, p. 8). Importantly, the Inquiry also found that 'for older people around 20% of bed days were probably inappropriate if alternative facilities were in place' (Department of Health, 2000a, p. 8).

While the acute sector's ability to manage an increasing number of admissions through reducing numbers of beds has been partly attributable to the growth in day cases, it has also been managed through a sharp decline in the average length of time patients spend in hospital. From 1981 to 1996/97, average acute length of stay (per finished consultant episode) decreased from 9.3 to 5 days, while the average length of stay for people over 65 decreased from 66.1 to 18.6 days (Vaughan and Lathlean, 1999). Although this decline slowed towards the end of the decade, its impact had considerable implications for older people, who need longer to recover, creating pressures both within the acute health service (bed blocking) and on transitional and social care support, at a time when there had also been considerable changes in the availability of these latter services.

Before 1983, most publicly funded social care was provided directly by the public sector, through local authority social services residential, day and home care and housing departments. In the early 1980s, the availability of social security payments for care in private and voluntary sector residential and nursing homes for anyone qualifying for supplementary benefit, irrespective of need, (rising to £2.5 billion a year by 1993), led to a rapid expansion of this market, with independent sector nursing and residential beds increasing by 242% between 1983 and 1996. By contrast, the number of local authority residential beds fell by 43%, and the provision of home care to those aged 75 and over fell by 25%.

In parallel, the availability of social security monies in the 1980s enabled many health authorities to reduce their provision for long-term care, closing old and outdated geriatric and psychogeriatric wards and freeing revenue for use elsewhere (Audit Commission, 1997). Thus, during the 1990s, demand, particularly from older people, increased at a time when capacity within local authority-provided services was reducing. Expansion was taking place in the independent and voluntary sector, but at considerable cost to the taxpayer.

Changes in financial incentives

The 1980s and 1990s in the NHS were marked by a constant search for greater efficiency and productivity, as health organisations attempted to respond to





increasing demand within a resource limited framework. As a result, there were considerable incentives to encourage more economical use of existing services and to develop new options which might reduce overall costs. The introduction, under the Thatcher Government, of the purchaser/provider split intensified pressures to provide health services at the lowest possible cost, whilst the advent of general practitioner and total fundholding created interest in service innovation and a focus on reducing hospital stays and expanding community care.

In social services, the 1990s were characterised by a number of pressures: supply side changes (as indicated previously); changes in funding arrangements (specifically, the capping of funds previously available through the social services system and their transfer to local authorities through the Special Transitional Grant); and the requirement, under the NHS and Community Care Act 1990 (introduced 1 April 1993) to act as lead agency for arranging comprehensive packages of social care. These combined to create a climate of incentives to prevent premature admission to long-term residential community care and maximise people's ability to live (relatively) independent lives within their communities for as long as possible.

A new UK government

The newly elected Labour Government in May 1997 focused renewed attention on the operation of the increasingly pressured health and social care systems. Major early policy documents such as *The New NHS: Modern, Dependable* (Department of Health, 1997b) and *Modernising Social Services* (Department of Health, 1998b) addressed the need to modernise service delivery through greater responsiveness to patients' and clients' needs, and by improving the partnership between, in particular, the health service and social services, in order to provide 'seamless' care. Later policy documents have placed greater emphasis on the delivery of services 'closer to home' (Department of Health, 2000a).

In addition, and for the same reasons, there was increasing interest in international developments in hospital bed utilisation. The National Beds Inquiry noted, for instance, 'a number of healthcare systems in the USA operate on hospital bed days (per 1000 population) that are roughly half the current England average and below the rate of even the lowest health authority. Their admission rates and average lengths of stay are both one-third lower than in England.' The Inquiry also noted that, in contrast to England, in some countries, notably the Netherlands, Canada and the USA, hospital admission rates for older people had been 'flat or falling for many years. In these countries, increasing pressures for emergency care are dealt with in the community or in ambulatory or outpatient facilities' (Department of Health, 2000a, p. 10). Of particular interest to the UK Government was the conclusion that 'health systems with low hospital bed utilisation appear to be characterised by a large range of ambulatory and intermediate care facilities and/or strict control on hospital services and expenditures' (Department of Health, 2000a, p. 10), and there has been much recent discussion and analysis of the benefits of organisations such as Kaiser Permanente in the United States (Light and Dixon, 2004).



Net effect

Thus, by the mid to late 1990s, the coalescence of the factors outlined above created an environment in which both health and social care organisations had an interest in exploring alternative service options, both to relieve pressure on acute and residential care and to make more efficient use of resources. In creating local responses to service pressures, 'intermediate care' was developed out of local necessity.

Policy development

As indicated earlier, the development of intermediate care is an interesting example of a grassroots service response to local pressures which has become mainstream policy. Its history demonstrates the important interplay between local service initiative and Government interest in stimulating an effective response to perceived service problems. The development of Government policy is traced below.

Although its formal history is short, three phases of policy development concerning intermediate care are already visible:

- *The early phase*, characterised by the search for a meaningful definition and ad hoc service developments.
- *The second phase*, when the requirement to develop intermediate care services became mainstream Department of Health policy and additional funding for both health and social services stimulated growth and expansion.
- *The current phase*, when Government policy is focusing on more effective coordination and integration – at professional, service and agency level – to create a 'whole systems' approach.

The early phase: mid-1990s to 2000

In the late 1980s and early 1990s, a number of experimental schemes, aimed at rehabilitation after hospital care, and often to support earlier discharge from acute hospitals, emerged on an ad hoc basis in the United Kingdom. In October 1996, a King's Fund seminar drew attention to these developments and to their potential to address some of the critical system pressures faced by both the health and social service sectors (Steiner and Vaughan, 1996).

During the later 1990s and in 2000, a number of other agencies and bodies commented on the potential of rehabilitation services to help to address service pressures, including the Department of Health, the (then) NHS Executive, the Social Services Inspectorate, the House of Commons Health Select Committee, the Royal Commission on Long Term Care for the Elderly and the British Geriatric Society. In addition, the Audit Commission published three reports: *United They Stand* (1995), *The Coming of Age* (1997) and *The Way to Go Home* (2000), which drew



Box 1.1 Intermediate care: early policy questions.

- What is it?
- Is rehabilitation the same as intermediate care?
- Is intermediate care a separate system or level within the total care structure?
- Is intermediate care an alternative to acute care or supplementary?
- Which types of service can be categorised as intermediate care (e.g. is rehabilitation on an acute site to be considered in this category)?
- Who are the target audience (i.e. older people only or should intermediate care cover those with serious and chronic disabilities)?
- What is the proper location for intermediate care services (i.e. 'a bridge between hospital and home' that is, not including home, or excluding services on an acute hospital site)?

attention to the shortcomings in the way in which health and social services worked together to develop services that would offer alternative options to unnecessary hospital, residential care or nursing home admission, or which could help vulnerable patients to recover greater independence following discharge.

In parallel, the Government issued a number of policy documents, particularly *Better Services for Vulnerable People* (Department of Health, 1997a) and *Better Services for Vulnerable People: Maintaining the Momentum* (Department of Health, 1998a), which emphasised the contribution that rehabilitation could make to the management of demand across the health and social care economy; the requirement for health and social services to work in partnership was also emphasised by section 31 of the Health Act 1999.

The evolution of thinking about intermediate care services during this early phase was marked by the search for a viable definition of the subject, which sought to answer a series of policy questions set out in Box 1.1. The questions themselves are an indication both of the terminological difficulties (compounded by different perceptions within different agencies, organisations and professional groups) and of the variety of models being developed. Although interest was growing, there was no formal Government policy statement about 'intermediate care'.

The second phase: 2000 to 2004

The year 2000 marked a watershed: for the first time, the description 'intermediate care' was given formal recognition in the National Beds Inquiry (Department of Health, 2000a). The second phase is therefore characterised by increasing certainty about definition and the emergence of a clear Government strategy and dedicated funding, albeit with a particular focus on older people as the target audience.

The key policy milestones in this phase are:

- *Shaping the Future NHS: Long-term Planning for Hospitals and Related Services*. The National Beds Inquiry (Department of Health, 2000a).





- *The NHS Plan: A Plan for Investment, A Plan for Reform* (Department of Health, 2000b).
- *Intermediate Care HSC 2001/01: LAC (2001)1* (Department of Health, 2001a).
- *National Service Framework for Older People* (Department of Health, 2001b).
- *Securing our Future Health: Taking a Long-term View*. The first Wanless Report (HM Treasury, 2002).
- *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (Department of Health, 2002a).
- *National Service Framework for Older People – Supporting Implementation. Intermediate Care: Moving Forward* (Department of Health, 2002b).

The contributions of each of these policy documents are briefly outlined below.

The National Beds Inquiry: 2000

The National Beds Inquiry examined recent trends in acute hospital activity, comparing bed usage in the UK with international experience. For the UK it 'found evidence of significant inappropriate or avoidable use of acute hospital beds', and in particular 'for older people, around 20% of bed days were probably inappropriate if alternative facilities were in place' (Department of Health, 2000a, p. 8). Arising from these findings, the Secretary of State consulted on three scenarios for the future development of care:

- Maintaining current direction, with no attempt to transfer services from hospital into community settings.
- Active development of acute bed focused care, where a wider range of services, including rapid assessment and rehabilitation, would be provided mainly in a hospital setting.
- Care closer to home, where there would be a major expansion of community health and social care to support the development of intermediate care services in order to avoid unnecessary admissions to acute care and to facilitate earlier discharge and a return to functional independence. Under this scenario acute hospital services would be focused on rapid assessment, stabilisation and treatment.

Option 3 was accepted, and subsequently developed as part of the NHS Plan.

The NHS Plan: 2000

The NHS Plan (Department of Health, 2000b), issued in July 2000, contained, amongst many developments, proposals for a major new programme to promote the independence of older people through developing a range of intermediate care and related services. It suggested a number of service models, with the stated aims of:



Box 1.2 Intermediate care: expected outputs.

- At least 5000 additional intermediate care beds and 1700 non-residential intermediate care places, together benefiting around 150 000 more older people each year
- Rapid response teams and other avoidable admission prevention teams benefiting around 70 000 more people each year
- 50 000 more people enabled to live at home through additional home care and other support
- Carers' respite care services extended to benefit 75 000 carers and those they care for compared with the 1999/2000 base line

All compared with the 1999/2000 base line.

From *Delivering the NHS Plan: Next Steps on Investment, Next Steps on Reform* (Department of Health 2002a). Crown copyright. Reproduced with permission from the Controller of HMSO and the Queen's Printer for Scotland.

- Helping people to recover and regain independence more quickly.
- Enabling easier discharge from acute care.
- Avoiding unnecessary long-term care.

The Plan explicitly provided for an extra £900m investment by 2003/4 to support these developments in the health and social care sectors. The NHS would receive approximately £405m, the balance relating to resources provided to local government, mostly for the personal social services. Tangible outputs expected by March 2004 from this investment are shown in Box 1.2.

The expectation from these intermediate care developments was that inappropriate acute admissions and avoidable delays in discharge would be dramatically reduced.

The Plan identified intermediate care as a key test of improved partnership between health and social services, and the Commission for Health Improvement, the Audit Commission and the Social Services Inspectorate were given responsibility for monitoring both progress towards the targets and the operation of effective joint working between the agencies.

Health and Local Authority Circular HSC 2001/01: LAC (2001)1

This circular was the first detailed statement of Government policy on intermediate care and provided 'initial guidance' on:

- The definition of intermediate care and appropriate service models.
- Responsibility for intermediate care and the role of the independent sector.
- Funding for intermediate care and community equipment services and charges for local authority services.

With regard to definition, the circular was prescriptive in stating that intermediate care should be regarded as describing services which meet all the following criteria:





Box 1.3 Intermediate care models.

- *Rapid response*: designed to prevent avoidable acute admissions by providing rapid assessment and diagnosis for patients referred from GPs, A&E, NHS Direct or social services and, if necessary, rapid access on a 24-hour basis to short-term nursing or therapy support and personal care in the patient's own home.
- *Hospital at home*: intensive support in the patient's own home.
- *Residential rehabilitation*: a short-term programme of therapy and enablement in a residential setting (e.g. a community hospital, rehabilitation centre, nursing home or residential care home) for people who are medically stable but need a short period of rehabilitation to enable them to regain sufficient physical functioning and confidence to return safely to their own home.
- *Supported discharge*: a short-term period of nursing and/or therapeutic support in a patient's home, to enable the patient to be discharged from acute care and to allow a patient to complete his/her rehabilitation and recovery at home.
- *Day rehabilitation*: a short-term programme of therapeutic support, provided at a day hospital or day centre.

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- Focused on preventing unnecessary admission to health or social care facilities, and facilitating earlier discharge from hospital.
- Involving a comprehensive assessment and individual care plan, designed to maximise independence.
- Time-limited, normally lasting no longer than six weeks.
- Involving multi-agency input, but with a single assessment framework and record, and shared protocols.

It contained a specific framework of service models as shown in Box 1.3.

Critical to the effective functioning of intermediate care was the role of the care coordinator, who would have responsibility and accountability for developing care pathways and protocols for access to services, and for ensuring that intermediate care was integrated across primary care, community health services, social care, housing and the acute sector. The circular advised local NHS bodies and councils to appoint jointly one coordinator in at least each health authority area initially.

The National Service Framework for Older People: 2001

The *National Service Framework for Older People* encapsulated the Government's determination to deliver real improvements for older people and their families. In particular, Standard 3 was devoted to a detailed description of intermediate care services. The Standard is as follows:

'Older people will have access to a new range of intermediate care services at home, or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary

hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long term residential care.' (Department of Health, 2001b, p. 41)

The *National Service Framework* defines the aim of intermediate care as 'to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living' (Department of Health, 2001b, p. 41). The use of the term 'integrated services' is interesting, reflecting the Government's concern to move forward from the fragmented approach which characterised the early phase and to avoid the confusion over definition, a strategy further emphasised by the later statement in the document that 'the key to this next phase of intermediate care development is integrated and shared care, including primary and secondary health care, social care, and involving the statutory and independent sectors' (Department of Health, 2001b, p. 42).

In contrast, it is interesting to note recent decisions in Scotland, where, in March 2003, the Scottish Executive made clear that they had decided not to pursue the label 'intermediate care', arguing that it was unclear what distinguished intermediate care from 'good, patient-centred mainstream services' and preferring the words 'integrated care' (Petch, 2003).

Standard 3 indicated that intermediate care services should focus on three key points in the pathway of care: responding to or averting a crisis; active rehabilitation following an acute hospital stay; and where long-term care is being considered.

Fundamental to the successful and effective delivery of intermediate care was:

- An open and effective partnership between health and social care agencies, involving a commitment to joint planning and joint investment.
- The requirement for providers to ensure that patients offered intermediate care support had guaranteed access to specialist assessment, diagnosis and treatment if required.
- The provision of care by a coordinated team, including, as appropriate, general practitioners and hospital doctors, nurses and physiotherapists, occupational therapists, speech and language therapists and social workers, with support from care assistants and administrative staff.

Other policy documents

Government policy on the development of intermediate care has been further emphasised in both the first Wanless Report (HM Treasury, 2002) and in the second report on the NHS Plan (Department of Health, 2002a). The former report, highly influential in persuading the Government to announce, in the April 2002 budget, investment of an additional £40 billion for the health service up to 2007/8, together with a 6% increase in funding over three years for the personal social services, stated 'the review believes the current balance between health



and social care is wrong: in particular, care is too focused on the acute hospital setting' (HM Treasury, 2002, p. 106). The latter document, while re-emphasising the requirement 'to prevent hospital admission and to provide more rehabilitation', stated that 'although progress has been made towards breaching the "Berlin Wall" between health and social care, there are still too many parts of the country where a failure to cooperate means that older people fail to get the holistic services they need' (Department of Health, 2002a, p. 32).

This last point was re-emphasised in the National Audit Office Report *Ensuring the Effective Discharge of Older Patients from NHS Acute Hospitals*, published in 2003, which commented on the 'mixed results to date' on joint working between health and social services to reduce delayed discharges (National Audit Office, 2003).

Finally, in the paper *Intermediate Care: Moving Forward* (Department of Health, 2002b), an assessment of progress to date was made, the guiding principles for intermediate care were explored, a series of useful practical case studies was presented (together with a list of success factors to guide implementation), and a useful review of research evidence to date was included.

Thus, the second phase of policy development was marked by a rapid and prolific production of policy statements. The reality in terms of implementation, however, did not meet Government expectations. Many examples of good practice had emerged, but there were still numbers of health and social care systems where services were less well developed, and where fragmentation and poor integration with other services were evident.

The current phase

The year 2004 marked another watershed in the development of intermediate care services. As indicated above, several major targets outlined in the NHS Plan were to be achieved by March 2004; if met, much needed extra service capacity will have been created. In addition, three major research projects on intermediate care, commissioned by the Policy Research Programme at the Department of Health, jointly with the Medical Research Council, are nearing completion. These projects involve:

- A national evaluation of the costs and outcomes of intermediate care services for older people.
- A comparative case study and national audit of intermediate care expenditure.
- A multi-centre study of the effectiveness of community hospitals in providing intermediate care for older people.

Their results will provide important information, and evidence, about the development of intermediate care across the country, its effectiveness and comparative costs, and the outcome for both service users and carers, and for the health and social care systems as a whole.

As the 2002 Department of Health paper *Intermediate Care: Moving Forward* stated: 'In many ways . . . intermediate care is still in its infancy and it depends



on new ways of working within complex partnerships' (Department of Health, 2002b, p. 4). The early, and to some extent the second, phases of development have been marked by innovation but also, in some places, by inconsistency and fragmentation. There is now a need, taking into account reliable, evaluative evidence, to create more coherent services, integrated across local health and social care systems. Intermediate care services are 'quintessentially, about partnership between organisations and professions' and yet 'one of the reasons that people have yet to enter into effective partnerships is that they may not know who all the partners are, or should be, and how they interact with each other. There is a need to understand system dynamics – components and interactions – both conceptually and in quantifiable terms' (Department of Health, 2002b, p. 6). The current phase of development will hopefully be marked by both a greater investment in effective, inter-agency, partnerships and by the creation of coherent local networks providing intermediate care services, where these services can clearly be recognised by their function of providing targeted, short-term care to prevent avoidable admission to hospital or long-term care, of facilitating earlier discharge, and above all, of enabling vulnerable people (be they older people or people with a variety of chronic disabilities) to maximise their independence.

Unresolved policy and implementation issues

A number of major policy and implementation issues remain to be resolved before the full potential of intermediate care can be realised, and some of the key questions are outlined below.

In terms of policy:

- Is the concept and definition of intermediate care sufficiently well understood, and, if understood, accepted generally, to provide a robust platform for moving forward?
- Which patient or client groups should be the beneficiaries of intermediate care support? Most focus to date has been on the needs of older people, but people with chronic physical disabilities and people with mental health problems may equally benefit.
- Is there good evidence to suggest that intermediate care services are:
 - delivering better outcomes for patients or clients than more traditional models?
 - accepted and supported by patients or clients and by their carers (do we understand the demand placed on carers by intensive support at home)?
 - cost effective?
- How is the question of charging for services (in relation to social care) to be resolved?



- What guidance, if any, is necessary to ensure that the principle of ensuring timely access to the appropriate levels of specialist care is implemented for all users of intermediate care services?
- What guidance is necessary to develop appropriate clinical governance mechanisms within intermediate care?
- Critically, will local health and social care systems be able to fund, and then sustain, the levels of investment required for effective intermediate care interventions or will this require further Government support?

In terms of implementation key concerns are:

- The action required to support effective partnership arrangements in areas of the country where joint working has not been effective in delivering intermediate care.
- The need to ascertain which models of single assessment work best and how they can be disseminated.
- The training and development implications of intermediate care services.
- The mechanisms likely to be most effective in disseminating examples of good practice.
- The most appropriate arrangements for commissioning intermediate care.

Funding remains a major hurdle to the development of coherent local services. Although both the NHS and the social services are now receiving the considerable extra funds promised in the April 2002 Budget, the issue of their allocation remains: will appropriate sums be allocated to these services, thus relieving pressures elsewhere, or will other targets and policy imperatives take precedence? Once again, it will be interesting to observe the interplay between local initiatives and developments and Government policy.

Summary

Intermediate care must be carefully defined in order to make sense to those who are interested in developing these services locally. A general definition is suggested in the Introduction to this chapter and the range of services now recognised under this title are included in Box 1.3. In its early development phase, intermediate care emerged as a grass roots response to local service pressures; it was only later (from 2000 onwards) adopted as mainstream government policy. The major policy statements on intermediate care are contained in the National Beds Inquiry consultation document (Department of Health, 2000a), the NHS Plan (Department of Health, 2000b), the Health Service and Local Authority circular issued in January 2001 (Department of Health, 2001a) and the *National Service Framework for Older People* (Department of Health, 2001b).

The context in which intermediate care developed was shaped by a number of factors, including changes in demand for, and supply of, health and social



care, financial pressures which created incentives for greater efficiency in resource use, and the election of a new Labour Government in May 1997. To work effectively, intermediate care networks require commitment and effective partnerships between health and social care agencies and the provision of care by coordinated teams of health and social care practitioners.

A number of key policy questions remain to be answered in order to obtain the maximum benefits for patients. Particularly important is the allocation of appropriate funding to develop coherent local networks capable of delivering the targeted services required.

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