

- Services which involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

2.2 Thus, an I.C. service should have a clear function (admission prevention and/or post-acute care), incorporate comprehensive (multi-disciplinary) assessment, have an enablement process, offer time-limited contact (to differentiate I.C. from maintenance services) and involve multi-agency working.

2.3 The BGS largely supports the DH definition of I.C. with the proviso that the six week time limit is inappropriately prescriptive for some patients and can hinder person-centred care. The BGS membership also reports many examples of so called I.C. that fall short of the detailed description as provided in HSC 2001 above. Transitional care, in which older people are moved and simply cared for while awaiting social services assessment, is a common misconception of I.C. This type of care can reduce pressure on acute beds but involves an additional and unnecessary move for a frail older person. I.C. admission criteria that have been locally discussed and agreed between agencies and professionals are a simple practical method to ensure a shared understanding of an I.C. service is achieved. Additionally, the routine provision of care summaries at the point of discharge from I.C. should be regarded as good practice and should be sent to the professional originally responsible for instigating the I.C. admission to provide feedback on the appropriateness of the referral.

3. EXAMPLES OF INTERMEDIATE CARE SCHEMES

3.1 There are several service models of I.C. Common examples include:

- Community hospitals
- Hospital-at-home schemes
- Rapid response teams
- Hospital supported discharge teams (NHS or social services or joint)
- Community Assessment and Rehabilitation Schemes (CARTs)
- Private/Voluntary/Social Services sector nursing/residential home rehabilitation
- Stroke rehabilitation outreach teams
- Nurse-led units
- Day hospitals (see Geriatric (Medical) Day Hospitals - http://www.bgs.org.uk/Publications/Compendium/compand_4-4.htm)

3.2 A risk for I.C. teams and services is that they become isolated from other mainstream primary and secondary care services. A whole system, integrated approach is considered essential to successful I.C. (9) but has been hard to achieve in practice (6). Insufficient integration has been shown to be associated with ineffective outcomes (10). Another concern has been that many I.C. services are overly selective with rigid criteria that exclude many potential recipients of I.C., commonly those with cognitive impairment. Routine, regular specialist input from a consultant geriatrician is one practical method to maintain a broad approach to an I.C. service.

4. THE EVIDENCE BASE FOR INTERMEDIATE CARE

4.1 The evidence base for I.C. remains insufficiently robust to allow dogmatic conclusions. However, there is sufficient research evidence to describe I.C. service models that are more likely, or conversely less likely, to be effective or cost-effective.

4.2 Local I.C. evaluations have been helpful and, in areas where I.C. has become a mature and established service, there is evidence for reduced admissions to acute hospitals and reduced residential/nursing home placements. However, these local evaluations, useful though they have been, have seldom included formal assessments of personal outcomes for patients and carers, and have also lacked control/comparison groups so that clear inferences are difficult.

4.3 A Cochrane systematic review of the randomised controlled trial (RCT) evidence (12 trials) suggests that day hospital care is at least equivalent in effectiveness to comprehensive geriatric assessment in traditional settings but may be more expensive (11). Early discharge to a community hospital providing multi-disciplinary care is associated with increased independence and has similar cost-effectiveness compared to post-acute care in general hospitals (n=490) (12). Nurse-led units provide a safe alternative to traditional hospital wards but are associated with considerably increased length of hospital stay such that they are unlikely to be cost-effective (10 trials) (13). The single trial of care home based rehabilitation demonstrated considerable additional length of stay but without health gain or reduction in need for institutional care (14).

4.4 Hospital-at-home (HaH) schemes are currently the best RCT supported I.C. model (22 trials). A HaH service is defined as: “.....a service that provides active treatment by health care professionals, in the patient’s home, of a condition that would otherwise require acute hospital in patient care, always for a limited period.” (15). It is a condition flexible service (e.g. DVT, COPD, hip fracture, frail older people), is I.C. function flexible (admission avoidance, early discharge, palliative care) and is an excellent foundation service for a more comprehensive I.C. service (e.g. HaH plus social service care, HaH plus community rehabilitation).

4.5 A Cochrane systematic review that compares HaH with hospital care reports improved patient satisfaction but possible increased carer strain, uncertain evidence for cost-savings, and uncertainty over clinical outcomes with a worrying trend to increased mortality in the sub-group of studies involving older people with medical conditions. Separate reviews of I.C. using specialist teams as an early discharge service for people recovering from a stroke (16), or from an exacerbation of COPD (17), are more encouraging with good clinical outcomes and savings in hospital bed days used. Given some of the uncertainties associated with the HaH evidence base, the BGS recommend that strong clinical governance systems should be in place (see below) so that local I.C. services can demonstrate the quality and safety of their care.

4.6 Practical experience with HaH indicates that it has advantages as a valuable core service to encourage multi-agency working. One operational opportunity is to encourage new or existing HaH services to have a strong presence within A&E departments – at the interface between A&E and medical assessment units and/or the medical/elderly care admission process. This ensures timely and robust medical assessments, thereby improving clinical safety. This also integrates the I.C. service into mainstream care, facilitates linkages to other services, such as falls assessment, and focuses the I.C. where it is strategically required to increase local health service capacity.

5. Intermediate Care and Specialist Medical Assessment

5.1 The clinical assessment of older people is often complex. It requires time, patience, skill and a systematic approach. Visual impairment, deafness, foot lesions, anaemia, chronic heart failure, Parkinsonism and medication side effects are just a few examples of common background problems in older people that are all too easily overlooked, but can be readily attended to once identified with big quality of life impact for the individual.

5.2 Sudden changes in health – typically presenting in functional terms such as ‘unable to cope’, or as falls, “confusion,” or collapses (“found lying on the floor”) – suggest an underlying acute illness. These acute illnesses need to be sought positively and thoroughly as even “simple” illnesses, such as a chest infection or dehydration, can be difficult to detect.

5.3 The aim of I.C. services is to offer a genuine choice of care setting for ill older people. However, there is an associated responsibility to ensure that, whatever the setting, the medical component of care is consistent and of high quality (7). Community-based admission avoidance services (such as direct admission to a nursing home, community hospital or home-based care) should similarly not disadvantage an older person as far as a specialist medical assessment is concerned. Indeed, these patients could be particularly vulnerable as they can bypass the usual acute health care services and failure to identify underlying acute illnesses,

and other important conditions, is an obvious concern. Admission avoidance I.C. services based in casualty or on medical assessment units (MAUs) have an advantage in that serious (e.g. fractures) and life threatening (e.g. acute myocardial infarction) conditions will have been excluded before transfer to I.C.

5.4 The medical assessment of patients referred to an I.C. service will depend on local circumstances but is likely to include input from one or more of the following:

- consultant geriatrician
- consultant community geriatrician
- general practitioner, some with a specialist interest in older people
- staff grade specialist in older people.
- Nurse practitioner, nurse consultant or specialist nurse

5.5 Ideally, the professional providing the medical component of care should be integral to the I.C. team. But, as a minimum expectation, there should be locally agreed procedures for timely specialist medical advice and assessments such as telephone support, ready access to local day hospitals and to elderly care/psychiatric out-patient clinics. Clear arrangements for timely access to diagnostic services are also essential. The I.C. team caring for the patient need to have a skill mix that takes into account the complex needs frail older people whose health status often fluctuates. It is essential that the I.C. team have skills for supporting sub-acute management when necessary (eg. urinary catheterisation, fluid balance, safe oxygen treatment, assessment of swallowing) and that training to maintain competency in these areas is available.

6. CLINICAL GOVERNANCE AND INTERMEDIATE CARE

6.1 Clinical governance is an essential part of maintaining and improving service quality in NHS organisations and departments. It needs to be applied equally in the context of I.C. services so that quality of care and patient/user safety can be demonstrated. There are several components to clinical governance but risk management, clinical audit, critical incident reporting and staff training are of particular relevance to I.C. services. Monitoring of clinical governance is under the auspices of the Health Care Commission. Managers and staff working in I.C. will therefore need to be satisfied that an appropriate clinical governance framework is in place. It is helpful to incorporate clinical governance into a new service from its inception as this promotes a culture of reflection, discussion and incremental quality improvements. Acting on the views of service users is a particularly powerful approach to ensuring a high quality, patient focused service.

6.2 I.C. services should not work in isolation but require close involvement of other mainstream health and social service departments such as elderly care, psychiatry of old age, housing, primary care. It is therefore helpful to have some clinical governance service review meetings attended by representatives of other departments and organisations. This ensures a wider ownership of I.C. service work and promotes integration into other mainstream services.

7. CONCLUSION

7.1 The National Service Framework for Older People (NSF) has heralded the widespread introduction of I.C. services in England. The main justification has been a needs-based one: that community services for physically and mentally infirm (frail) older people are fragmented, under-developed and poorly co-ordinated. This situation has resulted in a strategic imbalance with an over dominant hospital health care sector for older people with chronic conditions. The new I.C. services are therefore expected to prevent unnecessary hospital admissions, support discharges, and maximise independent living. The extent to which they are able to achieve these aims is as yet unclear (18). Medical assessment, treatment and surveillance of patients receiving I.C. is an essential component of these services and the BGS strongly supports and encourages the involvement of consultant geriatricians and psychogeriatricians in the planning and delivery of I.C. services. Each department of medicine for the elderly should assess the

need for such services in conjunction with commissioners of health and social care. In order to aid such developments the BGS is keen to see an increase in the number of consultant geriatrician posts with significant and specific dedicated community activity.

8. MAIN POLICY GUIDANCE

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Author: Professor J Young for BGS Policy Committee