

Medical aspects of intermediate care

Report of a Working Party

FEDERATION OF MEDICAL ROYAL COLLEGES

Royal College of Physicians of Edinburgh

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December 2002

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OF THE UNITED KINGDOM

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11 St Andrews Place, Regent's Park, London NW1 4LE

ISBN 1 86016 176 6

Text editing and layout by the Publications Department
of the Royal College of Physicians

Typeset by Dan-Set Graphics, Telford, Shropshire

Printed in Great Britain by Sarum ColourView Group, Salisbury, Wiltshire

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Foreword

Intermediate care has been widely welcomed as an opportunity to reinvest in assessment and rehabilitation services particularly targeted at older people. Although there are differences within the UK in terms of terminology, planning, frameworks and approaches to intermediate care, comprehensive assessment is essential, and appropriate medical input is vital. This report:

- ▶ 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 progression
- ▶ 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.

Although much of the report is directly applicable to geriatric medicine and rehabilitation of older patients, there are clear implications for other chronic conditions. We hope that intermediate care will have a broader remit, and believe that other specialties have much to learn from the experience of geriatricians. All those planning to develop new intermediate care services should recognise the need for investment in frontline staff to strengthen and support the major reorganisation of services that is needed.

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Executive summary and recommendations

In the last two years there has been a national proliferation of intermediate care type schemes. These now need to be formalised and organised, to ensure the future success and clinical safety of intermediate care, and to meet the targets and expectations set out in the National Plan¹ and National Service Framework for Older People.² These schemes need to be quantified and evaluated, and their place in the total pattern of care determined.

This report concentrates on one model of intermediate care that specifically focuses on the needs of older people. Wider lessons can also be learnt for other patient groups and for chronic disease management.

This Working Party into medical aspects of intermediate care makes a number of recommendations:

- 1 Intermediate care needs to be part of a defined whole-system service within any local health and care community. Appropriate, coordinated, collaborative medical input from both primary and secondary care physicians from the inception of any service is needed to achieve the medical goals of intermediate care.
- 2 Medical input from both primary and secondary care needs to be appropriate to intermediate care. Participating doctors need accreditable training in:
 - clinical skills in the diagnosis and management of older people with complex needs
 - team-building skills and leadership skills
 - communication skills
 - strategic understanding and judgement, particularly in the respective contributions to care in high- and low-dependency environments
 - training and expertise in rehabilitation.
- 3 Intermediate care may offer career opportunities for both general practitioners and consultants with appropriate skills, and may provide opportunities for career evolution for senior clinicians who have the necessary skills. Professional development required to support intermediate care services by existing doctors may require ‘backfill’, which requires serious consideration by the Workforce Confederations.
- 4 All primary care organisations and commissioners of care will wish to ensure that a quality service is provided with appropriate medical input – a patient-centred service founded on the relevant evidence base*.

*Primary care organisations do not exist in Northern Ireland or Scotland; there is no commissioning role for primary care in Scotland.

- 5 To provide clear clinical governance, intermediate care services need to be integrated with existing services to ensure a comprehensive system of care, usually with a single defined point of entry.
- 6 The operation and management of intermediate care requires routine multidisciplinary groups with input from primary and secondary care as appropriate.
- 7 In order to ensure clinical governance, improve the knowledge base, and to share experience, intermediate care schemes should provide for the routine collation of local data. Governance should include a variety of quality indicators to reflect structures, process and outcome.
- 8 The Department of Health should, through the development of appropriate information systems, provide the opportunity for audit and research on a local and national level in order to evaluate the impact of these developments in terms of process, clinical and non-clinical outcomes.
- 9 All schemes must have in place clinical governance arrangements involving the use of national standards, programmes of audit and systems for recording clinical incidents. Pathways of care, integrated through primary and secondary care, may facilitate the provision of care and the analysis of data. A minimum set of standards required to provide an acceptable level of care is included in Appendix 1.

I Introduction

Terms of reference

1.1 The Federation of the Royal Colleges of Physicians of the United Kingdom commissioned a Working Party to report on intermediate care and its consequences for medicine and physicians. Specifically, its remit was:

- ▶ to review the current progress in delivering the new intermediate care services envisaged in both the NHS Plan¹ and the National Service Framework for Older People²
- ▶ to make recommendations from a medical perspective to ensure future progress in delivering effective national intermediate care type services.

Areas considered by the Working Party

1.2 The following areas were considered by the Working Party:

- ▶ evidence from the Department of Health and other relevant bodies regarding what and how intermediate care is currently delivered to meet National Plan targets¹
- ▶ the current position regarding medical aspects of intermediate care
- ▶ current and future relationships for medical services in both the hospital and the community
- ▶ the training implications for medical staff
- ▶ current and future governance and audit arrangements.

2 Development of intermediate care services

2.1 In England, intermediate care was developed in its present form as a response to two key reports. The 1997 Audit Commission report³ concluded that there was too little investment in preventative and rehabilitation services, and the National Beds Inquiry⁴ found that a significant number of older people stayed in acute hospitals longer than appeared necessary or desirable.

2.2 The English National Service Framework (NSF) for Older People says the goal of intermediate care is to ‘*provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living*’.²

2.3 Intermediate care services, as envisaged in the NSF, should:

- ▶ be targeted at people who would otherwise face unnecessarily prolonged hospital stays or avoidable admissions to acute inpatient care, long-term residential care or continuing NHS inpatient care
- ▶ be provided on the basis of a comprehensive assessment resulting in a structured individual care plan that involves active treatment and rehabilitation
- ▶ be designed to maximise independence and to enable patients/users to remain or resume living at home
- ▶ involve short-term intervention typically lasting no longer than six weeks and frequently as little as one to two weeks or less
- ▶ involve interdisciplinary working in the framework of a single assessment process, a single professional record and shared protocols
- ▶ be provided by a core team of professionals including general practitioners and hospital doctors, nurses, physiotherapists, occupational therapists, speech and language therapists, and social workers, with support from care assistants and administrative staff.

2.4 For medical care, the underlying principle set out in the NSF² is one of shared care between general practitioners and hospital-based consultants. Locally agreed protocols and pathways will determine the precise arrangements within a particular intermediate care service, and ensure that at any time the focus of medical care is clear. In most cases, the hospital-based consultant will be a specialist in geriatric medicine or old age psychiatry, but other medical specialists, for example in rehabilitation medicine, diabetes medicine, or chest medicine, may be involved if this best meets the older person’s needs. The arrangements should, wherever possible, build on existing local relationships and good practice.

2.5 Neither Scotland⁵ nor Wales has explicitly taken on board the Department of Health policy concept of intermediate care, but both historically have some community-based resources, in particular community hospitals. These continue to provide a range of services, many of which

would fit the NSF definition (para 2.2). The National Assembly for Wales has recently established a working group to review the issue and prepare guidance for NHS bodies that wish to establish services within Wales.

2.6 The Scottish Association of Community Hospitals uses the broader definition of intermediate care as defined in Anglia and Oxford:⁶

Those services that do not require the resources of a general hospital, but which are beyond the scope of the traditional primary care team. This includes:

- intermediate care which substitutes for elements of hospital care, which we have called ‘substitutional care’, and*
- intermediate care which integrates a variety of services for people whose health needs are complex and in transition, which we have called complex care.*

3 Current activity, resources and models

3.1 The National Service Framework for England stated that intermediate care services should focus on three key issues:

- ▶ responding to, or averting, crisis
- ▶ active rehabilitation following an acute hospital stay
- ▶ considerations concerning long-term care.

3.2 The Department of Health (DH) presented evidence of the evolution of intermediate care as a concept rather than a specific type of service. This has led to a very wide diversity of models: the DH website indicates that there are over 1,000 projects in England and Wales. In terms of measurable activity, the DH reports that current investment in intermediate care is in line with that envisaged in the National Plan (see Table 1).

Table 1 Current investment and targets in intermediate care

Targets 2003/4	Position in March 2002
5,000 extra beds by 2004	2,400 extra beds
1,700 extra non-residential places	6,200 extra non-residential places
220,000 people to benefit	126,000 people benefit
£900m investment by 2003/4	

3.3 No information is available to indicate whether extra medical, therapist or nursing staff have been put in place to deliver this extra reported activity.

3.4 The success factors identified by the DH for local intermediate care services include:

- ▶ vision, drive and leadership
- ▶ shared objectives
- ▶ coordination (strategic and operational)
- ▶ appreciation of potential and limitations
- ▶ clear professional accountability
- ▶ good organisation of finance and logistics.

3.5 Important issues recently identified by the DH, working with the National Older People's Task Force, include:

- ▶ integration of intermediate care services into the whole local system of health and social care
- ▶ medical input and responsibility
- ▶ equitable access to intermediate care services so that no patient groups, especially those with dementia, are excluded.

3.6 There appears to be no central definitive database of current intermediate care schemes, in particular their lines of responsibility, aims and objectives.

3.7 A fragmentation of identity was found in a national survey of care home environments⁷ for rehabilitation of older people, with very significant discrepancies in information provided by local health and social care agencies. Many schemes are very small, and there appears to be considerable flux in the type and number of schemes in any one locality from year to year, which complicates any measurement of effectiveness or cost benefit.

3.8 A recent report, based on two national surveys for the British Geriatrics Society and Age Concern,⁸ raised concerns about the implementation of intermediate care. Those surveyed identified a lack of input by both medical staff and older people into planning new services, and a significant lack of specialist input into clinical management. Local intermediate care services appeared to remain fragmented; there was a widespread absence of clear accountability or formal structures for monitoring progress; and in a small but significant number of organisations there had been a re-badging of hospital beds as intermediate care beds.

3.9 The Working Party received research evidence regarding models of intermediate care, including 'hospital at home', community rehabilitation teams, nurse-led units, nursing home-based intermediate care, day hospital care for older people, and community hospitals.⁹ Overall, the existing evidence base supporting intermediate care service models is not robust, though hospital at home schemes are the most extensively researched. Development and evaluation are likely to progress in an iterative manner. Key factors to be taken into account are that:

- ▶ needs should be determined locally depending on geography, resources, expertise and enthusiasm
- ▶ clinical success factors should include:
 - enthusiasm of staff
 - multidisciplinary working
 - interagency working
 - protocols
 - strategic development
 - allied health profession (AHP) empowerment to lead
 - effective links to secondary and primary care services
 - joint ownership
 - mobile communications

- ▶ organisational success factors include:
 - coordinated care
 - single point of entry
 - central organisational structure
 - single assessment process (SAP).

3.10 The Working Party consider that to achieve the NSF criteria (para 2.3), to address the three key operational foci (para 3.1), and to maximise the potential of all activity, a single coordinating point of access to the diversity of intermediate care services in each locality will usually be required. This should be

- ▶ covered operationally
- ▶ staffed managerially by appropriate collaborative interdisciplinary groupings, bridging primary, secondary and social care, including the private sector.

Medical leadership should be collaborative between primary and secondary care physicians, the precise balance of responsibilities being determined locally in accordance with available accreditable skills, experience and commitment.

4 The organisation of medical care and training

4.1 In the NSF there is no monopoly role for any clinical group in intermediate care. Unsurprisingly, the Working Party repeatedly highlighted the importance of both general and specialist medical input into intermediate care, and established that effective comprehensive services will only result when practitioners work together. The Working Party concluded that the principles described in this document for aspects of medical training and organisation of medical care could be extended to programmes for chronic disease management, and other patient groups.

4.2 Although intermediate care type services are for all patient groups, the vast majority of patients being treated are older people with complex problems. Therefore it is essential that access to a defined intermediate care service for that group is quantified and ensured. These intermediate care services should encompass proven effective interventions such as comprehensive geriatric assessment (CGA), and condition-specific care (eg stroke).

4.3 Comprehensive geriatric assessment comprises ‘the evaluation and treatment of the medical, functional, psychological and environmental problems of older patients’.¹⁰ At the heart of intermediate care for many older patients is the process of CGA. Comprehensive geriatric assessment by a multidisciplinary team, providing it includes specialist geriatric medical input, is effective when coupled with ongoing responsibility for the implementation of care.¹¹ The positive outcomes include reduced mortality and reduced institutionalisation rates, coupled with improved functional status. These have been most convincingly demonstrated in modern inpatient geriatric medical assessment and rehabilitation units. Comprehensive assessment should, however, be available for patients in all age groups.

4.4 The Cochrane Collaboration work on stroke¹² demonstrates that by bringing together multidisciplinary systems, changing the process of care provided to patients, and managing patients on a specialist stroke unit, the numbers of those alive are likely to increase, as well as those living at home at one year after the stroke, as opposed to those managed on a general medical ward. This demands specialist medical leadership.

4.5 Comprehensive geriatric assessment requires the involvement of a multidisciplinary team in comprehensively assessing an individual, formulating a management plan, delivering treatment and interventions, monitoring outcomes and tailoring recommendations and interventions. In addition to a doctor with accreditable expertise in the care of older people, the key members are usually nurses, therapists and social workers, with access to other specialist services as required (eg hospital investigations, chiropody, homecare services). A basic assessment may be carried out by any one team member, but a comprehensive assessment requires the skills of the team as a whole. A very high proportion of older people who present with an apparently nonmedical event, such as a fall or loss of mobility, do in fact have an underlying or contributing medical problem. For this reason, arrangements for planned and emergency medical support, as well as for each of the other individual disciplines, must be made clear in all intermediate care schemes.

4.6 The Working Party found that there were key skills necessary from doctors involved in building, leading and working in intermediate care environments. These included:

- ▶ confident, mature clinical skills in the diagnosis and management of people with complex needs
- ▶ team-building and leadership skills
- ▶ excellent communication skills
- ▶ strategic understanding, particular of the balance of care between high- and low-dependency environments
- ▶ training and expertise in rehabilitation
- ▶ confidence to work in a low technology environment.

4.7 Many primary care physicians have been involved in intermediate care type schemes and community hospitals over many years, and are competent at managing such services, from experience, from working with local secondary care services, and sometimes from specific knowledge such as that provided by the Diploma in Geriatric Medicine.

4.8 Established consultants in geriatric medicine generally have a greater depth of training in the assessment and rehabilitation of older people. However, some more recent trainees may have had less exposure than is desirable to clinical practice and collaboration with primary care colleagues in the community. A recent survey suggests that only 5–10% of current specialist registrars (SpRs) in training are genuinely interested in going directly into a consultant job with a significant intermediate care component.

4.9 The Working Party agreed that SpRs in geriatric medicine do need new training to be competent and comfortable to accept responsibility for intermediate care schemes. Training would need to encompass:

- ▶ experience of primary care and community care (with the possibility of some common training)
- ▶ awareness of intermediate care models
- ▶ knowledge and understanding of the agencies involved, and of cross agency management
- ▶ experience in modern day hospitals, rapid response teams, hospital at home, long-term care, respite care, 'step down' beds, and community-based rehabilitation
- ▶ evaluation, reporting and governance of services.

4.10 For general practitioners (GPs) interested in intermediate care there may be a number of opportunities to gain the skills and expertise required. The Working Party endorsed a recent joint statement by the Royal College of General Practitioners (RCGP) and the Royal College of Physicians of London,¹³ setting out the principles and the routes for development of general practitioners with a special interest (GPwSI) and is keen to see early progress. One pathway could use the Diploma in Geriatric Medicine from the RCP with a revised and revamped curriculum leading to a joint examination with the RCGP. The British Geriatrics Society (BGS) and RCGP

are currently pursuing, in joint discussions, the objective of a mutually agreed approach to GPwSI training in the field.

4.11 The Working Party agreed that intermediate care schemes provide valuable educational opportunities for all doctors in training. However, the professional development required to support intermediate care services by existing doctors may require ‘backfill’, which needs to be seriously considered by the Workforce Confederations.

4.12 The Working Party was keen to address the issue of ensuring adequate specialist input into integrated community intermediate care type services for older people, while agreeing that most day-to-day and out-of-hours care will continue to be provided by GPs.

4.13 The concept of consultant career evolution, in particular for physicians specialising in geriatric medicine, attracted much positive comment. Geriatricians have over the last ten years been increasingly involved in acute general medicine in hospital, which takes time away from other aspects of geriatric practice. Yet access to acute medicine for older people in a district general hospital (DGH) has been a major factor in improving medical care, and must not be compromised. After 15 years as a consultant or a GP the possibility of a different type of work, new challenges, and the ability to build and achieve new services in an area involving practical working partnerships with key stakeholders, such as social services and primary care, might seem very attractive, together with the possibility of a reduction in emergency commitment.

4.14 The Working Party strongly supports initiatives to allow the knowledge of experienced medical practitioners to be put to use, coordinating and integrating what is currently a very fragmented process.

4.15 For commissioning purposes, the Working Party wished to give primary care organisations an indication of the amount of community-based consultant time that would be reasonable to purchase in the current state of development, particularly in England. Although this must vary with local demand and experience, especially in local primary care input, current practice indicates that there should be at least five fixed sessions of consultant time per 200,000 of the population. Equally, it is inevitable that more clinical input will be necessary in primary care to sustain effective intermediate care.

4.16 Examples of the use of such sessions demonstrate:¹⁴

- ▶ better working across primary and secondary care
- ▶ improved liaison with social services
- ▶ a focus on chronic disease management
- ▶ input into quality improvement in long-term care
- ▶ clinical responsibility for a rehabilitation ward in a community environment
- ▶ specialist opinions available to GPs and other staff who are concerned with community-based patients
- ▶ integrating and leading programmes of chronic disease management, eg Parkinson’s disease, specialist nurses for cardiac failure, diabetes.

5 Clinical governance and audit

5.1 Clinical governance is ‘a framework through which NHS organisations are accountable for both continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’¹⁵

5.2 Clinical practice in the UK has received intense scrutiny in recent years and the development of intermediate care should embrace the lessons of the Bristol Inquiry.¹⁶ Governance in intermediate care will need to ensure the inclusion of social aspects of care, and of diagnosis, treatment and clinical outcomes.

5.3 The Working Party considered it was essential for intermediate care, however defined, to be delivered within a framework of clinical governance, which should be integral and designed at the outset and not a *post hoc* consideration.

5.4 Clinical governance arrangements should embrace the Donabedian principles for assessing the quality of care including attention to the ‘structures’, ‘processes’ and ‘outcomes’ of care.¹⁷

- ▶ Structure ‘denotes the attributes of the settings in which care occurs.’¹⁷ It includes complying with minimum standards, for example those regulated by the National Care Standards Commission in England.¹⁸
- ▶ Process ‘denotes what is actually done in giving and receiving care.’¹⁷ It includes those processes advocated in the National Service Framework for Older People and in evidence-based pathways of care and protocols such as those published by specialist bodies, eg the RCP and Scottish Intercollegiate Guideline Network (SIGN) in Scotland.
- ▶ Risk management, clinical incident reporting and clinical audit are all aspects of procedural governance. These should facilitate reporting to the new National Patient Safety Agency.
- ▶ Outcomes ‘denote the effects of care on the health status of patients and populations.’¹⁷ They should include clinical measures and personal outcomes that demonstrate a patient-centred service, responsive to patients needs. Ultimately, it should be possible to establish benchmarks through the adoption of a competent ‘single assessment process’ and the use of modern database management.

5.5 The clinical governance of intermediate care must ensure that the *potential beneficial outcomes* proposed for patients, carers and the NHS as a whole are delivered, including:

- ▶ the preferred option for clinical care
- ▶ maintained social networks
- ▶ minimised risk of institutionalisation

- ▶ reduced risks of hospitalisation
- ▶ reliable and adequate access to rehabilitation
- ▶ facilitation of continuing care and support
- ▶ seamless care between primary and secondary care
- ▶ the most cost-effective use of beds
- ▶ continuing professional development and training
- ▶ information support systems which support all of the above
- ▶ patient involvement in the process and evaluation.

5.6 The *potential risks* of intermediate care that governance should monitor include:

- ▶ delayed or missed access to secondary care when necessary
- ▶ failure to ensure access to appropriate specialist opinion and management
- ▶ failure to provide coordinated multidisciplinary rehabilitation
- ▶ failure to ensure high levels of discharge planning
- ▶ inadequate communications between primary and secondary care to support effective coordination of patient care.

5.7 Examples of indicators for auditing the ‘structure’ (organisation) of care are shown in Box 1.

BOX 1 Indicators of the structure (organisation) of care

- ▶ Are mechanisms in place for multidisciplinary assessment?
- ▶ Are appropriate professional staff available for assessment and therapy, including medical input, the input of AHPs, care managers and additional relevant professionals?
- ▶ Are structured care plans utilised?
- ▶ Is a standardised single assessment process utilised?
- ▶ Are mechanisms in place for single multidisciplinary record-keeping?
- ▶ Is there a mechanism for defining responsibility for clinical care and social care?
- ▶ Are there standard protocols or guidelines for the management of specific conditions?
- ▶ Are there mechanisms for training and ongoing education of staff?
- ▶ Are there mechanisms for involving patients’ relatives and carers in assessment, therapy and care planning?

5.8 Examples of indicators for auditing the ‘process’ of care are shown in Box 2.

BOX 2 Indicators of the process of care

- ▶ Has detailed information been obtained for each patient/user using an accredited measurement to assess any change in health, functional ability or social dependency?
- ▶ Has information been obtained by relevant professionals?
- ▶ Has an appropriate examination been carried out?
- ▶ Have there been regular meetings of the multidisciplinary team to monitor progress and plan further therapy and care?
- ▶ Have relevant investigations been carried out?
- ▶ Has progress been monitored on a regular basis by a coordinated multidisciplinary team using standardised assessments?
- ▶ Have all patients had appropriate specialist opinions?
- ▶ Have standardised protocols or guidelines informed individual care?

5.9 The Working Party received examples of using integrated care pathways in a rehabilitation setting that illustrated the practicality of this approach.^{19,20}

5.10 Measuring and auditing outcomes of care in a meaningful fashion to monitor safety are at an early stage of development in the NHS. Nevertheless, the Working Party recommended that all services should:

- ▶ collect a minimum dataset using National Dataset definitions
- ▶ record admissions, deaths, readmissions to hospital
- ▶ record discharge destination and particularly institutionalisation rates.

5.11 Examples of indicators for auditing the ‘outcome’ of care are shown in Box 3.

5.12 A minimum set of standards required to provide, in the view of the Working Party, an acceptable level of intermediate care is included in Appendix 1.

5.13 For all services the responsibility for clinical governance must be clearly attributable, with minuted clinical governance service review meetings. The minutes of such meetings would form key evidence for the Commission for Health Improvement (CHI) inspections in England.

5.14 For consultant specialists in geriatric medicine there are comprehensive guidelines for clinical governance.²¹

5.15 The biggest challenge is the possible dissipation of intermediate care services without adequate integration or assessment locally, or nationally, to ensure long-term survival. The Working Party supported a national Government-funded audit initiative along the lines of the Stroke National Sentinel Audit Project.²²

BOX 3 Indicators of the outcome of care*Hospital activity outcomes*

- ▶ For patients with specific conditions (eg falls, chronic obstructive pulmonary disease, cardiac failure, deep vein thrombosis), is the length of hospital stay reduced? Are the number of hospital admissions reduced?
- ▶ For all older people admitted to hospital, is there a reduction in the rate of increase in the number of acute hospital admissions? Is there a reduction in the length of stay?

Outcomes relating to therapy associated with intermediate care

- ▶ Are there improvements in functional ability as measured by standardised scores?
- ▶ Are there improvements in cognitive ability as measured by standardised scores?
- ▶ Are there improvements in quality of life?
- ▶ What is the percentage of people leaving intermediate care to continue in their own homes?
- ▶ What is the percentage of intermediate care patients admitted to hospital within one month of intermediate care episode of care?

Outcomes relating to intermediate care activity

- ▶ What percentage of people with specific conditions are managed by intermediate care?
- ▶ What is the length of stay on an intermediate care programme?
- ▶ What professional groups are involved in assessment, rehabilitation, discharge planning?

5.16 A whole system approach, with a single point of entry and referral in each local health and care system, will facilitate monitoring and delivery of intermediate care services.

5.17 In summary, for clinical governance, the Working Party agreed that:

- ▶ mechanisms for clinical governance and audit should be incorporated into all intermediate care service developments
- ▶ assessment should use standardised validated tools that conform to the requirements of the single assessment process and that can be readily and reliably applied in practice
- ▶ data should be prospectively available to the NHS to reflect premorbid state, morbid state and exit state for all people receiving intermediate care
- ▶ governance should include a variety of quality indicators to reflect structures, process and outcome
- ▶ electronic data collection may facilitate such processes and investment should be made for central data aggregation to allow comparative audit and national benchmarking of care
- ▶ data should be available on all patients in intermediate care services
- ▶ a minimum set of standards is required for all schemes (see Appendix 1).

Appendix I

Standards on medical aspects of intermediate care

These standards are proposed based on:

- ▶ the recommendations emerging from this report
- ▶ the General Medical Council's recommendations in *Good Medical Practice*
- ▶ principles of accountability and responsibility enshrined within the clinical governance framework of the NHS.

These standards acknowledge the plethora of models of service which could be encompassed within the intermediate care definition.

- 1 All patients within an intermediate care service should have contemporaneous medical records.
Conformance test: When audited, all patients in the intermediate care service should have a record which begins on their entry into the service.
- 2 The contemporaneous medical record should be available to any doctor visiting the patient for the purpose of care when the patient is an inpatient in an intermediate care service.
Conformance test: When audited, all inpatients in the intermediate care service should have a record which begins on their entry into the service.
- 3 The intermediate care service should have a clear statement of purpose, which as a minimum includes whom the service is for and what it intends to do.
Conformance test: When audited, the purpose of the service, as detailed by the doctor in medical charge, should be the same as on the supporting documentation of the service.
- 4 Any intermediate care service should be able to describe the components of the service.
- 5 The components of the intermediate care service should be defensible by evidence from research or from the standpoint of a reasonable body of medical opinion.
Conformance test: When audited and questioned, the doctor(s) involved in the service should be able to defend the existing components of the service, or demonstrate that they have suggested better ways of providing the service.
- 6 The doctor who is medically accountable for the care in the service should be known to all the patients and staff.
Conformance test: When audited, any mentally competent patient or member of staff should be able to name the doctor medically accountable for the service.

- 7 The designated clinician who leads and is accountable for the intermediate care service should be known to all patients and staff.
Conformance test: When audited, any mentally competent patient or member of staff should be able to name the person who leads the intermediate care service.
- 8 The responsibilities for routine medical care of the patients in an intermediate care service should be made explicit and incorporated into a job plan if it involves a consultant physician.
Conformance test: When audited, any doctor who is involved in the intermediate care service should be able to produce a job description of their role, and if the doctor is a consultant physician a supporting job plan should be available.
- 9 The responsibilities for out-of-hours medical care of the patients in an intermediate care service should be made explicit, and incorporated into a job plan if it involves a consultant physician.
Conformance test: When audited, the out-of-hours medical care should be set out clearly in the operational plan of the unit, and the unit should be able to demonstrate that it works well in practice.
- 10 Complaints about medical care should be investigated appropriately and remedial action taken. The doctor should play a full and active role.
Conformance test: When audited, all complaints about medical care should be available, and management should be able to show a thorough investigation, medical participation and responsive changes to the service and/or individuals within it.
- 11 The intermediate care service should be able to demonstrate that its outcomes are at least as good as the service it replaces.
Conformance test: When audited, the deaths, transfers and institutional care rates from the intermediate care facility should be better than the service it replaces, or existing comparative services.
- 12 Inpatient services should have an explicit policy with evidence of implementation on cardiopulmonary resuscitation (CPR).
Conformance test: When audited, case notes for inpatients should clearly demonstrate the decisions taken with patients with regard to CPR.

Appendix 2

Useful web references for intermediate care

Department of Health website
www.doh.gov.uk/index.html

Intermediate Care Compendium – *A compendium of Intermediate Care and other recent initiatives in place or under development in the South West*
www.doh.gov.uk/swro/intermediatecare.htm

King's Fund – Rehabilitation and Intermediate Care

- ▶ *supports a learning network for intermediate care coordinators*
- ▶ *produces an intermediate care manual/toolkit*
- ▶ *runs a Rehabilitation Development Network*

www.kingsfund.org.uk/eHealthSocialCare/html/rehabilitation.htm

National Care Standards Commission
www.carestandards.org.uk/

National Service Framework Older People
www.doh.gov.uk/nsf/olderpeople.htm

NHS National Plan
www.doh.gov.uk/nhsplan/

Scottish Intercollegiate Guidelines Network
www.sign.ac.uk/

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