

Intermediate care: integrated, local and personal

The coronavirus disease 2019 (COVID-19) pandemic has heightened awareness of the need to scale up safe, effective and person-centred community alternatives to acute hospital care, particularly for people with chronic conditions or frailty. Across the globe, the effects of COVID-19 and reconditioning following lockdown are driving new approaches to rehabilitation and intermediate care (Prvu Bettger *et al.*, 2020). Intermediate care services are complex multi-dimensional interventions delivered in hospital and/or in community settings (National Institute for Health and Care Excellence, 2017). In a recent international Delphi study, experts from 13 countries defined intermediate as a range of time-limited services, at the interface between home and acute hospital, which ensure continuity and quality of care, promote recovery, and restore independence and confidence (Sezgin *et al.*, 2020a). The continuum of intermediate care services includes Rapid Response alternative pathways for falls; Hospital at Home; discharge to assess and nurse-led transitional care programmes; reablement and rehabilitation at home; and step up and step down beds in community hospitals, care homes or skilled nursing facilities.

The heterogeneity of these services makes benchmarking challenging (NHS Benchmarking Network). Although some studies report positive outcomes for some service elements, a recent scoping review noted limited evidence for effectiveness of intermediate care on emergency department attendances, institutionalisation, function and cost-effectiveness (Sezgin *et al.*, 2020b). This is in part because traditional healthcare research methods such as randomised control trials are not well-suited to evaluate complex multidimensional interventions within complex health and care systems (Greenhalgh *et al.*, 2018). There is a need for more mixed methods studies such as the recent study by Young *et al.* (2020), to understand what works, where and for whom, in order to design integrated models that meet the needs of different age cohorts and care groups.

International perspectives

This special issue adds to the growing literature on intermediate care and will be of interest to those involved in planning, commissioning or delivering health and care services. The eight papers share valuable insights from research and practice in seven countries spanning four continents. Each paper explores one or more of the key elements acknowledged as critical for effective intermediate care (Sezgin *et al.*, 2020a).

Elias and colleagues share a case study of an innovative community alternative to acute hospital care for frail older people in South Eastern Sydney, New South Wales. They co-designed inclusive referral pathways with emergency healthcare responders and later extended access to other services such as advocacy, police, fire and rescue to provide an integrated and holistic response for people with complex needs and circumstances within a local network.

The mixed methods study by Ribbink and colleagues focuses on bed-based intermediate care in an Acute Geriatric Community Hospital (AGCH) in Amsterdam. The value of post-acute care in Community Hospitals is well-established in many high income countries, and rehabilitation for older people is a core function of the contemporary community hospital (Davidson *et al.*, 2019; Winpenny *et al.*, 2016; Pitchforth *et al.*, 2017; Young *et al.*, 2020). However, community hospitals are still a relatively novel concept in the Netherlands. The authors reported that older patients admitted to the AGCH valued the quiet “home-like” environment and found it conducive to recovery and reconnecting with family.



In a study of transitional care following discharge from a tertiary hospital in Singapore, Lee and colleagues found both telephone follow-up and home visits reduced the length of stay and readmissions in a high risk group of patients with complex needs. As the pandemic has accelerated adoption of digital solutions to enable virtual consultations and remote decision support (Greenhalgh *et al.*, 2020), we can expect to see more studies of technology-enabled transitional care.

The paper by Oyesanya and colleagues shines a welcome light on the need for transitional care in younger adults with traumatic brain injury discharged home from a trauma unit in Southeastern USA. Their paper reminds us that reablement and intermediate care are not just for older adults.

Zazzera and colleagues describe a relatively new concept of Operating Centres for Transitional Care. These functional centres are being established within Local Health Authorities in Italy to provide a range of “back office” functions such as referral management, bed management, governance and virtual case management for people requiring transitional care. These functions are critical to ensure a timely urgent response and efficient use of a network of services. The authors highlight the vital role of effective communication and sharing of information between professionals and care settings in order to optimise flow, provide the correct intensity of intervention, enable continuity and coordination of care and assure high quality intermediate care. This paper will resonate with systems aspiring to coordinate their community services in order to meet the 2 h crisis response standards in England (NHS England, 2021).

Davenport explores audit of quality and outcomes in her study of adopting the Therapy Outcome Measure in an adult social care and reablement service in England following its integration within a Community NHS Trust. The author reflects on the importance of understanding different professional values, cultures and approaches to identifying and recording personal and system outcomes when introducing tools to measure quality and outcomes of interventions. Barron and colleagues describe the potentially transformative impact of using the IoRN2 assessment tool within an integrated intermediate care and reablement service in Scotland. The authors reflect on the positive contribution of the tool in enabling person-centred strength based and outcomes-focused conversations at point of care, and in supporting respectful and collaborative practice by professionals from different disciplines working together in an integrated team.

Finally, Corbett and Lewis share a personal reflection on their experience of rapid redesign of a community Frailty Support Team in response to the pandemic. This paper reminds us that effective intermediate care requires adequate capacity, appropriate skill mix and training to ensure community staff have the appropriate technical and relational skills, professional support and supervision, and are able to access career development opportunities. Staff motivation, well-being and retention reflect the fourth dimension of the Quadruple aim and are critical considerations for workforce planning at a time when the health and care workforce is pandemic weary (Stein *et al.*, 2021).

Integrated, capable and fit for the future

The breadth of papers in this issue gives a flavour of the wide ranging capability required by the intermediate care workforce to support people with multiple complex care needs in the community. Required competences include skills in case management, care coordination, reablement and rehabilitation. Practitioners also require core competences in integrated care, particularly relational skills for inter-professional practice and collaboration with partners from different sectors (Stein, 2016) and person-centred leadership skills to support shared decision-making, self-management and health behaviour change (Kuluski *et al.*, 2020). As the intermediate care cohort is often frail, and one in four are reaching a palliative and end of life

care phase (Evans *et al.*, 2021), practitioners also need to be competent in identifying and managing frailty syndromes and end of life care.

The current management of frailty in the community is largely reactive, influenced by professional judgement and intuition, with little systematic training in frailty-specific screening and assessment (Papadopoulou *et al.*, 2021). The excellent work to develop a national capability framework for frailty (Health Education England, 2018) offers a strong platform from which to create a capability framework and structured interdisciplinary education for the intermediate care workforce. As we push the boundaries of the art of the possible in the community, we must invest in a community workforce that is integrated, capable and fit for the future.

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