

Intermediate care

Intermediate care

*What do we know about
older people's experiences?*

Alison Petch

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FOREWORD

It was said they wanted one door to knock on ... and to this very day they might have one but I don't know where the door is.

This report starts the discussion on what the various elements of what has been called 'intermediate care' look like from the perspectives of older people. The discussion can only be started as many of the initiatives to date have emerged without much attention to the views of older people. Indeed, as will be suggested below, it remains uncertain whether the identification of a distinct 'intermediate care' agenda is the best way forward.

The unattributed quotes within the text are taken from discussion with members of the West of Scotland Seniors Forum. Particular thanks are extended to those who contributed these insights – and many more to be used on other occasions.

INTERMEDIATE CARE: PREFERENCE OR PITFALL?

What is meant by intermediate care?

The term 'intermediate' is often used in a confusing way and is applied at different times to different services, settings or roles.

(Audit Commission, 2000, p. 21)

... there is a considerable amount of confusion, among both policy makers and practitioners, about what intermediate care really is.

(Stevenson and Spencer, 2002, p. 5)

These comments from two key reports highlight the need to clarify what is being talked about in any discussion that refers to 'intermediate care'. Traditionally 'intermediate care' has often been used to refer to a range of services at the boundary of primary and secondary care, although there have been differing assumptions as to the goal of intermediate care, the intensity of support provision and the appropriate target groups. Confusingly, intermediate care has also been used *within* the hospital as a term for units located between the intensive care unit and the general ward. This use is not pursued here. More recently, however, 'intermediate care' has been the term adopted by the Department of Health for a specific range of provisions designed

to avoid hospital admission or promote early discharge. In order to avoid confusion, the evolving nature of these definitions of intermediate care will be outlined.

The emergence of intermediate care

In a review of the literature on intermediate care completed in 1997, Steiner traced the range of service models which at various times and in various places have been put forward as intermediate care and offered a conceptual framework. Steiner concluded that intermediate care was a '*function* rather than a discrete service' (1997, p. 24) and suggested both a broad and a more narrow definition. First, 'intermediate care can be defined broadly to include a wide set of services designed to smooth the transitions between hospital and home, treat chronically or terminally ill people without recourse to hospital care, and prevent long-term institutionalisation' (p. 24). Defined more narrowly, intermediate care is 'that range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired' (p. 24).

A range of detailed case studies illustrating these earlier models of intermediate care is presented by Vaughan and Lathlean (1999). Despite the templates for evaluation offered by Steiner *et al.* (1998), there is not much evidence of how these projects have been experienced by those on the receiving end, although the authors feel able to comment: 'a question must be raised about whether Intermediate Care is giving patients what they want – and soft evidence would suggest that it is' (Vaughan and Lathlean, 1999, p. 72).

The need to prioritise some form of intermediate care for older people gained momentum following a report from the Audit Commission on health and social care for older people (1997), reinforced subsequently by the findings of the National Beds Inquiry (Department of Health, 2000a). The Audit Commission demonstrated that, with inadequate preventative and rehabilitative services, older people were being admitted to hospital unnecessarily and that those in hospital remained there longer than required. This in turn was leading to poorer outcomes, for example, people picking up infections in hospital, people with cognitive impairment becoming disorientated, and both social and professional support networks within the community becoming disrupted. This highlighted an urgent need to intervene in what the Audit Commission termed the 'vicious circle', to target resources on the provision of alternatives to the use of costly acute beds or unnecessary admission to residential or nursing home care.

The subsequent review by the Audit Commission of rehabilitation and remedial services for older people identified the complex range of services responding to rehabilitation needs across acute and community NHS trusts and social services, and identified intermediate services: 'these meet a range of needs for the medically stable with a focus on "confidence-building". Can be used post-discharge (step-down) or as a halfway house between home and hospital (step-up)' (Audit Commission, 2000, p. 11). The National Beds Inquiry selected 'care closer to home' as the preferred option for the future development of support.

Under this scenario there would be an active policy of building up intermediate care services (i.e. services designed to prevent avoidable admissions to acute care settings and to facilitate the transition from hospital to home and from medical dependence to functional independence).

The NHS Plan

The current form of intermediate care provision started to shape up with the NHS Plan (Department of Health, 2000b). This proposed a range of intermediate care services designed to bridge between hospital and home and to:

- help people recover and regain independence more quickly
- bring about swifter hospital discharge when people are ready to leave
- avoid unnecessary long-term care.

Investment of £900 million in intermediate care by 2004 was signalled. The development of intermediate care is intrinsically linked with the growing emphasis on partnership working between health and social care (and ideally other agencies) and with the concern to reduce the number of 'delayed discharges' – individuals remaining in acute hospital beds beyond the need for medical care.

The current focus of intermediate care was emphasised in a presentation in September 2000 by Ian Philp, National Director for Older People's Services at the Department of Health (quoted in Stevenson and Spencer, 2002, pp. 6–7). He contrasted what intermediate care should be:

- patient-centred, with the development of an individual care plan
- about facilitating access to acute rehabilitation and long-term care services based on need
- about active rehabilitation

- time-limited, with clear entry and exit points and responsibility for managing transition
- part of a whole system approach to the delivery of health and social care to older people and related groups

with what it is not:

- marginalising older people from mainstream services (a ghetto service)
- providing transitional care for older people pending long-term placement (a hotel service)
- solely the responsibility of one professional group (a dumping service)
- indeterminate care (a dustbin service)
- a means of funding all good things for older people (a honeypot service).

In the wake of the NHS Plan, Enderby and Stevenson (2000), working on developing the approach to intermediate care in Sheffield, mapped eight programmes of care based on eight categories of need. The aim was to produce a user-focused service.

We consider that it is appropriate for clients as well as relatives and professionals to have a clear idea of what programme they are on in order to improve acceptability, compliance and satisfaction and to assist in audit. Only too frequently clients are dissatisfied because they feel

they are not getting sufficient rehabilitation, as the service providers are viewing the needs of the client from a different perspective.

(Enderby and Stevenson, 2000, p. 39)

Intermediate care circular

Detailed guidance on intermediate care was issued in January 2001 (Department of Health, 2001a) following the commitment in the NHS Plan for England of investment of an additional £255 million by 2003/4 earmarked for intermediate care, giving a total NHS resource of £405 million. Parallel investment is being made in social services to develop the capacity of home-based support. Emphasis was placed on the role of intermediate care 'within a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, support for carers, and acute hospital care' (p. 2). It was anticipated that the provision for pooled budgets and other flexibilities of the Health Act 1999 would become the primary route for financing intermediate care, with intermediate care being regarded as a key test of the extent to which partnerships between health and social services are succeeding.

Perhaps mindful of the confusion around the identity of intermediate care highlighted above, the circular indicated the adoption of a standard definition.

Intermediate care should be regarded as describing services that meet all the following criteria:

- are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care

- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home
- are time limited, normally no longer than six weeks and frequently as little as 1–2 weeks or less
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols. (p. 6)

Particular emphasis was laid on the short-term nature of the care (typically one to two weeks for pneumonia, two to three weeks for hip fracture, four to six weeks for major surgery), with all care plans requiring a review within the six-week period. Although, as quoted above, intermediate care should be part of a seamless continuum, it should nonetheless stand as a distinct episode and should be distinguished from transitional care not involving active therapy, longer-term rehabilitation or support services, and rehabilitation that forms part of acute hospital care. 'Care closer to home' was regarded as a key principle, provision wherever possible to be in an individual's own home or in a community setting. Five specific service models were highlighted in this guidance:

- rapid response – the provision of rapid assessment/diagnosis followed by short-term support in an individual's own home to avoid hospital admission; such a service may also be provided in conjunction with appropriate 'step-up' facilities

- 'hospital at home' – intensive treatment in an individual's own home beyond that normally provided by primary care but not necessarily requiring acute hospital treatment, either to avoid admission or to enable earlier discharge
- residential rehabilitation – short-term therapy and enablement in a residential setting, for example, community hospital, rehabilitation centre, nursing or residential care home, to develop physical functioning and confidence prior to returning home; this may be 'step-down' following a stay in an acute hospital, or 'step-up' to avoid acute or longer-term residential care admission
- supported discharge – short-term support in an individual's own home to allow earlier discharge from an acute hospital, completing rehabilitation and recovery at home
- day rehabilitation – a short-term programme of therapeutic support at a day hospital or day centre which may be used in conjunction with other forms of intermediate care.

A number of detailed considerations are highlighted in the circular. A potentially important area relates to charging, with the recommendation that intermediate care should be free at the point of use, local authorities working with their health partners to facilitate such arrangements through the flexibilities introduced by the Health Act 1999.

National Service Framework for Older People

Provision of intermediate care was subsequently adopted in England as Standard Three of the National Service Framework for Older People issued in March 2001.

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. 13)

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' (p. 41).

The use of the term 'integrated services' is interesting in the context of recent decisions in Scotland. Scotland has not to date made use of the term 'intermediate care', although there has been the requirement to develop a rapid response team for each area, to provide home care support free of charge for up to four weeks following hospital discharge, and to develop more intensive home support packages. In March 2003, the Scottish Executive made clear that they had decided not to pursue the label of 'intermediate care'. Their argument is that it is unclear what distinguishes intermediate care from 'good, patient-centred mainstream services'. Indeed the drive for integrated care stemming from the work of the Joint Future Group embraces, it

is argued, the aims that are attached to intermediate care. 'We don't need the artificial vehicle of something called intermediate care if we can deliver integrated care.' Concern is also expressed that 'creating a new layer of service called intermediate care could just create yet more boundaries if it sat somewhere between secondary care and primary care'. (Quotes taken from speech by a Scottish Executive official to a conference on intermediate care.)

The National Service Framework for England emphasised that 'integrated and shared care', embracing primary and secondary health care and statutory and independent sectors, should be the priority for the next stage of development. Services were to focus on 'three key points in the pathway of care':

- responding to or averting a crisis
- active rehabilitation following an acute hospital stay
- where long-term care is being considered.

Specific targets were put in place: a jointly appointed intermediate care co-ordinator in each health authority and baseline mapping by July 2001; at least 1,500 additional intermediate care beds, at least 40,000 additional people receiving intermediate care services promoting rehabilitation and supported discharge, and at least 20,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared to the 1999/2000 baseline by March 2002; and by March 2004 at least 5,000 additional intermediate care beds and 1,700 non-residential intermediate care places, 150,000 additional people receiving rehabilitation and supported discharge intermediate care services and at least 70,000 additional people receiving preventative intermediate care compared to the baseline.

Intermediate Care: Moving Forward

The most recent policy statement on intermediate care both highlighted common 'success factors' and identified areas where further action was required. A diversity of schemes have emerged at the local level.

Often on a small scale, often dependent on the vision and drive of one or two committed individuals, nearly always on short term funding and lacking stability, intermediate care 'schemes' and 'projects' have taken shape.

(Department of Health, 2002, p. 5)

Proliferation has led to 'confusion and fragmentation. This in turn has led to inequality of provision and access, duplication of effort, reduced cost effectiveness and loss of impact' (p. 5). Future priorities include:

- the importance of ensuring that people with mental health problems, including cognitive impairment, have access to intermediate care services
- development of a clinical governance framework
- the need for an appropriate level of medical assessment and support
- the role of housing in promoting independence. (p. 3)

This review identifies a number of local evaluations of developments in intermediate care but identifies that these 'have seldom included formal assessments of personal outcomes for patients and carers' (p. 11).

Key questions

It is important to note that despite the high profile of intermediate care, the evidence base is uncertain and 'remains patchy' (Department of Health, 2002, p. 11). Steiner (2001a) provides a useful overview of the evidence for the effectiveness of a range of intermediate care-type provisions. A stronger evidence base underpins the broader field of rehabilitation (Sinclair and Dickinson, 1998). Indeed questions remain as to the distinctions between intermediate care and rehabilitation, with recent suggestions that intermediate care may be being used as a route for reinventing rehabilitation.

However, as *Intermediate Care: Moving Forward* identifies, 'it is increasingly recognised that intermediate care is a *whole system* service constructed from individual service components' (Department of Health, 2002, p. 11). This suggests that provision as a whole needs to be looked at and that too rigid a focus on individual components and their evaluation may be misleading.

There is a range of questions which could target the perspectives of older people. These include:

- Is early discharge the preference of older people?
- What has been the experience of those discharged to home-based support?
- What are the views of older people on moving from hospital to an alternative location prior to going home?
- Do older people prefer to receive support in their own home in a crisis situation?
- What is the impact of time limits for the delivery of intermediate care?

- What is the impact on older people and informal carers of providing intensive support in their own home?
- In what ways does intermediate care contribute to or detract from the provision of a seamless service?
- How do older people respond to changes in support workers and providers?
- How do older people respond to the variety of charging mechanisms?

Many of these questions cannot yet be answered from the available evidence. They provide a framework, however, for various pieces of the jigsaw presented below.

The user perspective

The focus of this review is on the various elements of intermediate care as they are experienced by older people. This suggests an emphasis on individual accounts of elements of satisfaction and dissatisfaction, together with an exploration of how particular arrangements are experienced in terms of their impact on an individual's quality of life. The need for such a perspective has been well expressed by Steiner (2001b, p. 234):

With elderly patients, it is quality of life – not physical function – which is central. Thus, objective assessments must be joined with the subjective value placed by an individual on some particular capacity. What is an achievement for one patient (e.g. walking up and down stairs) will be irrelevant to another (e.g. someone who is wheelchair-bound, or someone else who is used to

jogging several miles a day). In the future, researchers as well as practitioners must explicitly take patients' own goals into account when they evaluate effectiveness. At present, few medical records even note what those patients' goals are, aside from the ubiquitous wish 'to go home'.

Care must be taken, however, when collecting older people's experiences, not to rely on too simplistic an interpretation of satisfaction. Bauld *et al.* (2000) have summarised from the literature a number of key considerations in measuring satisfaction amongst older people. They identify three main uses of data on satisfaction – as a measure of quality, as an outcome and as an indicator of the need for service reform. They also highlight a key factor.

User satisfaction is a complex concept. Its dimensions are related to lifestyle, past experiences, future expectations and the values of the individual.

(p. 318)

When asked general questions about satisfaction levels, people of all ages tend to respond positively; more detailed questioning is usually necessary to obtain more critical and considered responses.

Bauld *et al.* confirm, moreover, that older people consistently express higher levels of satisfaction than younger people. They also seem more likely to give the answers that they think service providers wish to hear. This may reflect a number of factors, including fear that an essential service might be removed, an unwillingness to criticise individual support workers, low expectations, and a lack of knowledge of alternatives or of desirable standards. A complex relationship between satisfaction

with services and with health status and more general well-being is also suggested.

These complexities are explored in more detail in Chesterman *et al.* (2001) who draw on the satisfaction of older people with care-managed support to demonstrate, for example, that arthritis, loneliness, problems keeping warm and an inner city location were all associated with reduced satisfaction. Work by Pound *et al.* (1999) has also demonstrated, in respect of provision of services following a stroke, that variation in satisfaction ratings reflected real differences in the provision of support. Higher levels of service received higher ratings.

Outcomes defined by older people

The work of the Social Policy Research Unit on user-defined outcomes in community care (Qureshi *et al.*, 1998; Bamford and Bruce, 2000) is of value in the current context of older people's perspectives on intermediate care. Against a backcloth of key themes of 'maximising choice' and 'control over one's life', Bamford and Bruce identified two groups of outcomes that are important to older people with dementia – quality of life outcomes and service-process outcomes.

Quality of life outcomes included:

- access to social contact and company
- having a sense of social integration
- access to meaningful activity and stimulation
- maximising a sense of autonomy
- maintaining a sense of personal identity

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- feeling safe and secure
- feeling financially secure
- being personally clean and comfortable
- living in a clean and comfortable environment.

Service-process outcomes included:

- having a say in services
- feeling valued and respected
- being treated as an individual
- being able to relate to other service users.

The sense of autonomy was of particular importance, remaining in one's own home signifying a sense of control.

There's a lot isn't there to be said to come home and to lock your door and it's your own place ... and do what you like.

(Bamford and Bruce, 2000, p. 556)

In the context of rehabilitation, the identification by older people of outcomes related to improving their physical and/or mental state should be added to the above list.

Models of intermediate care

Discussion of the various elements of intermediate care will focus first on initiatives designed to prevent the need for hospital admission; second, on initiatives such as rapid response teams which may support both prevention and early discharge; and finally on initiatives facilitating the discharge process for those in acute care.

Avoiding admission

Intensive support at home

We had this situation last year in our local forum. One of our members had gone to America, she was 87, 88, she'd gone to America. She walks with a stick because she's got osteoporosis but she's active. Went to America, fell and fractured her femur and had to come home by air ambulance. She lived alone, she had no near relatives, the nearest relative was her niece who lived in Paisley who had primary school children. When she came home, when she went to bed she couldn't get out, she couldn't bend, she couldn't do anything, she couldn't even get to the bathroom and her niece was struggling with this and she was coming up in the morning, taking the children to school, coming up and trying to look after and leave food for the aunt and then go back down in time for the school. I mean nearly impossible. And so we were fortunate at that time that we had a local social work officer who had come to speak to the group and we'd got to know him, so we phoned him and said 'look we've got a situation here, this lady lives alone, she's needing quite a lot of input' 'leave it with me' and within a day he had someone coming in who washed and dressed her in the morning, who prepared her food, who did her shopping and who came back in the evening and helped her into bed, or

she was in bed most of the day initially, and within a fortnight she was fine and back on her feet. She's back out walking about with her stick but, had that not happened, you wonder how long it would have taken her to get back into the swing of things and indeed would she ever have got back in, would she then be confined to a home because you know she'd become stiff and miserable because of her back but they had the physiotherapist in, they had the home help in, they had the, I don't know what they call it ... she came in and helped her with personal hygiene and prepared her food.

I'm 100% saying that the lady would be desperate to get home but she would have to be worried about who she was getting first, this nurse coming twice a day if she lived in a house where she's living herself and she's got to let this person in, how is she going to get off the sheet to let her in?

While it is well known that the majority of older people wish to remain within their own homes in the long term, and can be supported by intensive packages of care (Curtice *et al.*, 2002), there is less evidence on short-term preferences at times of crisis when there is an option of a non-hospital provision. This is an area where some detailed investigation of older people's views would be rewarding. Much of the development of rapid response teams (see below) has succeeded in avoiding admission, although initial evaluations (for example, McKechnie *et al.*, 1999) have only briefly addressed the experiences of recipients.

Step-up

A half way house, where they could accommodate, that would I think be acceptable to the elderly who fear and don't want to go into hospital. A lot of people really would

resist hospital but they might consider that and say 'you can just go in here for three days, you can go in for four days and if you're better in two days well you can just go home in two days.'

There's only one thing about these convalescent places, I'm just after losing my neighbour, she was 94, you know there was nothing up wi her, she was a wee frail body but there was nothing up wi her head and there was nae a thing she did nae see. So to give her daughter relief she said she would go over to this place quite near where we live but what they did with them, they put them into this big sitting room and the television was up in this corner and it was nae working very well. So she was a television fan and a snooker fan so all these things she could nae have because other old women did nae want to watch this. So there they were all stuck and the thing that was really annoying was they were all lug chairs and even if she wanted a wee gossip tae that woman she could nae get it which for her was a waste of time. It wasnae for her daughter because her daughter got peace to do whatever she wanted to do but for her it was an absolute, cause she liked to talk and she liked her snooker and her Rangers and whatever and she was just stuck there with this television that did nae work. I think if she had nae had a frail body she'd have got hold of thon television and threw it through the window.

Ashworth *et al.* (1996) reported on the use of four beds within an early 20-bed intermediate care facility in Lambeth for the provision of respite care. Admissions were restricted to four weeks. The maintenance of the 'core values of "home"' was promoted – atmosphere, personal autonomy and daily routine and the opportunity to bring a favourite armchair or a pet. Interviews with 40 patients revealed very high satisfaction ratings. Moreover, 73 per cent reported improvements in their physical

well-being, mainly because of access to members of the health team, while 75 per cent said it improved their psychological well-being through the social contact. Problems were reported around support provision: poor timing of ambulance transport, the quality of food, lack of ethnic foods and difficulties in meeting a need for a special diet, difficulties sharing a ward and security for personal items. There was a universal call for better information.

Dual function provision

Many schemes focusing on intermediate care would describe their aims as twofold, both preventing inappropriate admission and promoting early discharge.

Rapid response teams

We have a group, there's a nurse, an occupational therapist, there's a physiotherapist and something, I think there might be a social worker, there's four within it. Now the GP refers the client for this and they stay for a fortnight and they do your needs and they again I think supply what you need and it was folk would say have pneumonia or something and they weren't bad enough to go into hospital but they might be, they need obviously a lot of care at home.

Rapid Response Team I think is fine but we've got a lot of very vulnerable elderly people who never, who don't go to their GP or don't go very often and who deal with things on their own and gradually very often deteriorate when they're on their own and I feel ... there should be a facility for the local community to access the Rapid Response Team.

A dual provision scheme was the focus for one of the few detailed explorations of the responses of older people to such provision (Cornes and Clough, 2001). The number of user interviews, six, was relatively small, although two further interviews were completed with carers. The scheme in question, the Crises Support Service, had originally been developed in response to the government's 'winter pressures' and 'waiting list' initiatives in 1997/8, and aimed to provide enhanced health care in the community, providing GPs with easy access to rapid response services through the district nurse. Access to social care without charge was also available for 14 days, the maximum period on the scheme. Where support at home was not feasible, a range of alternative 'bed options' was purchased: residential and nursing home beds and a 'health bed' within a social services resource centre from which nursing, occupational therapy and physiotherapy services could be accessed. A scheme for joint social work and health assessment and care management was introduced, although still using the separate assessment schedules of the two services.

Cornes and Clough report that when older people were asked about their experience of the Crises Support Service they did not feel that the new scheme had been well explained to them – 'she was talking across me, one nurse to the other, and she told the other nurse that it was a new scheme and that she'd try to get me into this home' (2001, p. 185). The older people interviewed portrayed themselves as passive recipients for whom arrangements were being orchestrated by others. For the period of acute crisis this could be seen as positive – 'I was in such a state of shock and in so much pain that I didn't care where I went'; 'it was a case of I didn't care what happened' (pp. 186–7). Once the crisis had passed, however, there was the potential for greater interaction:

Researcher: Has anyone explained to you what happens when you can no longer stay on the Crises Support Service scheme?

Service user: I haven't a clue dear – I haven't a clue at all. I'm just putting all my trust in the system – whatever it is.

(p. 187)

Commentary by the researchers on this project, illustrated by a series of timelines for individual people, highlights the danger that intermediate care schemes may lead to further discontinuity, multi-referral and multi-assessment, rather than the intended continuity of care and seamless service – 'needless to say, such arrangements do not sit comfortably with the principle of continuity of care and invisible boundaries between different services' (p. 193); 'patients such as Mrs Fitzroy appear to be handed back and forth between different agencies and professionals' (p. 197).

An evaluation of the fast response service offered by the Rotherham Community Assessment Rehabilitation and Treatment Scheme is cited by Stevenson and Spencer (2002, pp. 26–7).

Hospital at home schemes

'Hospital at home' schemes can also offer opportunities for early discharge or avoiding admission. The evaluation reported by Wilson *et al.* (2002) of the Leicester Hospital at Home admission avoidance scheme is important for the attention it pays to reporting the views of older people and their informal carers. Unlike a number of earlier studies of hospital at home, the evaluation emphasised more qualitative approaches.

In addition to a satisfaction questionnaire with six core questions, semi-structured interviews were completed with both

older people and carers for both the hospital at home group and for a control group admitted to hospital. Older people had been randomly allocated to the scheme or to hospital. These interviews focused on the aspects of the two options that individuals particularly valued or had concerns about. Interviews were taped and transcribed and analysed for key themes.

The Leicester scheme was nurse-led, with additional inputs from physiotherapists, occupational therapists and generic health workers. Referrals were made by the GP who retained medical responsibility; the maximum length of stay on the scheme was 14 days, with daily input of between four and 24 hours of support. The scheme took a maximum of five people at any one time.

The results of this study endorse the potential of hospital at home. On the patient satisfaction questionnaire, scores were significantly higher for the hospital at home group on all but one of the six statements. The following are the statements, with individuals asked to indicate whether they 'strongly agree', 'agree', 'disagree' or 'strongly disagree'.

- I have been treated with kindness and respect by staff.
- The staff attended well to my personal needs.
- I was able to talk to the staff about any problems I might have had.
- I received all the information I wanted about the cause and nature of my illness.
- The doctors and nurses have done everything they can to make me well again.
- I am happy with the amount of recovery I have made.

The greatest contrast was found in communication with staff and in the care that they provided.

The semi-structured interviews were completed with 24 patients and 18 carers from the hospital at home scheme and 18 patients and seven of their carers from the hospital group. The former particularly valued the personal relationship with the nursing staff: 'it seems as if you are the only one, but you're not'; 'they were marvellous ... it was like having friends coming in' (Wilson *et al.*, 2002, p. 11). By contrast, in hospital 'they're talking "hospital language", you know what I mean? ... And then when they come on a ward round, you're laying there like a fish on a plate' (p. 11). Patients at home in the main reported feeling safe, although a few reported feeling vulnerable at night. However, similar problems were reported by those in hospital. The most favourable aspect of hospital at home related to the very nature of it being the individual's own home: 'probably being at home works better than a drug' (p. 12). Carers refuted any suggestion that hospital at home imposed increased demands.

Hospital discharge

Hospital discharge is one of the areas of practice that has been most difficult to get right. Key issues have been identified in a succession of reports (Neill and Williams, 1992; Marks, 1994; Jones and Lester, 1995; Taraborrelli *et al.*, 1998; Glasby, 2003) but, despite initiatives such as the Hospital Discharge Workbook, have remained remarkably resistant to change. The six problems identified by Marks (1994, p. 11) remain equally valid today:

- Older people in acute wards are not routinely asked about their home circumstances nor how they will cope after discharge.

- There is little information about medication and its side effects and practice in self-medication is not routine.
- Information on discharge policy and procedures is not widely available on wards.
- There is often inadequate notice of discharge.
- Transport arrangements are often poor.
- There are often delays and inadequacies in the provision of community services.

Supported discharge

As with other initiatives identified above, much of the evaluation of supported discharge does not focus directly on outcomes reflecting the accounts of older people themselves, although it may well be that there is an implicit link between other outcome measures such as whether the person remains at home and the acceptability of arrangements to the older person.

Hyde *et al.* (2000) presented a systematic review of studies which looked at the effects of supported discharge after an acute admission. These studies all predated the current intermediate care initiatives. The focus was on nine studies which had adopted a particular approach – what is termed a randomised controlled trial. This compares what happens to individuals receiving the special supported discharge arrangements with what happens to those discharged in the normal way. Only one of the studies measured what was termed ‘patient contentment’, although this did suggest a higher level of ‘contentment’ amongst the group receiving support. More generally, however, it was shown that more older people remained at home six to 12 months after the original admission if their discharge had been supported.

Early supported discharge

They've got a lot of scepticism to overcome if this is going to work, they have to sell this and make sure that we can be absolutely certain that this will happen.

You need people that'll take responsibility, in the hospital, the health service [*has*] responsibility, with the social work department will they still be taking that responsibility because at the moment nobody seems to have any responsibility for anybody that visits and everybody that visits and comes seems to do their own thing.

Mayo *et al.* (2000) have specifically addressed *early* supported discharge. In the context of stroke (and Canada), the extent to which prompt discharge combined with home-based rehabilitation led to more favourable outcomes was explored. The relevance of this study to this current review is its demonstration of the potential interaction between satisfaction levels and how an individual is progressing on other aspects of functioning. It showed that early discharge to home rehabilitation enhanced health-related quality of life and community reintegration compared to routine provision.

The researchers report that considerable qualitative information was volunteered by respondents.

A common theme from all these groups was that the intervention empowered the subject and his or her family to take charge of the care. The family, instead of being passive observers around the bedside of the patient, was now in charge and actively making decisions and taking action.

(p. 1022)

Rehabilitation/step-down facilities

That would help her mobility and perhaps her confidence and ... we are supposing that the input is there in order to raise her, fix her mobility, raise the confidence to keep her confidence fairly high about going home and able to direct bits of her life that she can, as she has done in the past, but it would have to be that and not one of those places where they're sat in front of the TV or playing at bingo ... It would have to be an active facility where she could really get on her feet and be helped to do that. And she's going to meet other people within units which is going to brighten her up and say well if they can do this here I might have folk coming into my own house.

A key dimension in any intermediate care facility is whether it is a dedicated facility solely used for intermediate care or whether there is dual use. Herbert (2002) reported on the use of Tomlinson Court, a sheltered housing provision, to facilitate intermediate care. A partnership between Housing 21, Derby social services (providing social care and occupational therapy) and Greater Derby Primary Care Trust (providing physiotherapy), ten independent living units were provided within the scheme for individuals unable to remain within or return to their own home following illness or increasing disability.

The evaluation was positive. Seventy-six per cent of users returned to a more independent lifestyle, with all users previously living in residential or nursing homes returning, in line with preference, to sheltered housing or their own homes. Users also required less home care on discharge from the service. High levels of satisfaction were reported by those that the service assisted to return to their own homes. The average length of stay, however, was seven weeks, suggesting, the report argues, that the six-week limit cited for intermediate care may be unnecessarily rigid.

The Centre for Evidence-Based Social Services is currently completing an evaluation of a 16-bed joint health and social care residential rehabilitation unit for older people following hospital discharge. This compares outcomes for those attending the unit with those returning home directly. Unfortunately for the current purpose, the first report to be published (Trappes-Lomax *et al.*, 2002) focuses on clinical and cost effectiveness rather than the perspectives of older people which will be addressed in a forthcoming report. The evidence of the clinical and cost measures shows few differences between the two options, although costs were distributed differently between the health and social care agencies. The clinical measures included health-related quality of life, as recorded on the SF12 (a standard assessment tool), and general morale and well-being, recorded by the Revised Philadelphia Geriatric Center Morale Scale. The opportunity was also taken to develop what has been termed a 'Cope-ability scale', designed to capture the ability to cope with the current demands of daily life as reported by the older people themselves.

These results suggest a question mark over the value of residential rehabilitation as an intermediate care option. The perspectives of the older people themselves may be critical. They will be reported in respect of the two options detailed above together with the perspectives of people who went to smaller units with three or four beds. Some early findings in respect of the joint unit have been reported in Stevenson and Spencer (2002, p. 29). Favoured features included the 'ordinariness' of the unit and of the staff, and the encouragement of independence and 'doing it for yourself'. Responses on what 'could have worked better' embraced four main categories:

- Users felt isolated from each other.
- Users complained of often being bored and lonely.
- Some users would have welcomed more constructive daily activities – the rehabilitation process seemed to focus mainly on physical function, but several users would have liked to learn new things and develop new interests.
- Most respondents would have welcomed continuity of contact and greater support after they left the unit.

In the enthusiasm for achieving discharge it is also essential that individual preferences and anxieties are not forgotten. The following quote came from one of our group participants:

I came from a family of nine. I have no family now bar my one daughter who, considering I nursed my own mother with a stroke and blindness for five years, I don't want her to need to do that for me because it's no joke over all those months, lifting and laying and what you're doing. But I'd be frightened and I must say in all honesty I can say here now, that would be my biggest fear, that you were going to take me out a hospital bed, if I couldn't look after myself, and bring me home and I was dependent on agencies, and I used to watch it with an old man across the road from me. He got a tuck in service at 6 o'clock at night and that was him tae the next morning. Now I would nae like tae lie there through the night, elderly people use the toilet as you know as often through the night and that's what would worry me. If my mind was still functioning and I'm lying there from 6 o'clock at night till I'm waiting on somebody coming to that door in the morning – that's existing, that's no living.

A more general overview of the potential to use nursing home beds for intermediate care is offered by Jacobs and Rummery (2002). Although this does not specifically discuss the perspective of older people themselves, it has major implications for potential provision if its conclusions are accepted. Key issues identified in interviews with home managers included difficulties in accessing GP services, in communicating with primary and secondary care, in accessing rehabilitation services and in obtaining equipment. Jacobs and Rummery conclude that these issues need to be resolved: 'otherwise, these placements will serve only to shunt the problem of bed-blocking into the independent sector and will not restore the functional independence of older people as intended' (p. 750).

A further alternative to acute care is reflected in the evaluation of a nursing-led intermediate care provision reported by Griffiths *et al.* (2001). This was a 19-bed ward in a district general hospital; eligible patients had a stable and low-intensity need for medical care and had active nursing needs. For the purposes of the evaluation, patients were randomly allocated to the unit or to the standard ward. The results suggested that the nursing-led inpatient unit was associated with longer stays, at greater cost, without any apparent benefit. More notable, however, is that this evaluation failed to address the perspectives of those cared for within the unit; it would seem unlikely that individuals would voluntarily opt for a lengthier stay without demonstrable benefit.

Issues of equality

The planning's terrific, I'll give you that 100%, the planning's terrific if you're living in a nice area with a nice home ... a lot of these old folk want to stay in the hospital, they don't want to come home, sorry about this they

don't, because they're in there, they've got a clean wee nightie, a clean bed and somebody like yourself coming over and saying 'there you go lass, there's a wee cup of tea'. They're going home to misery and hoping that the staff from the home helps, the social work are going to come out. They're no there.

One dimension has been lacking to date throughout this review, namely any reference to issues of diversity and equality. This reflects the failure across virtually all the studies which have been cited to address these issues. No reference was found to consideration of diversity in intermediate care provision. Whether this is despite the proliferation of small projects or as a result of it one can only speculate.

Three key areas need to be addressed. First, there is a concern with equity of provision between different areas. One of those contributing to the discussion for this review reflected at one point on the experience that had been recounted by another: 'that was Hollywood compared to what happens where we live'. Despite standard requirements to develop crisis or rapid response, there is already evidence of fragmentation and inequity (Department of Health, 2002) which bodes ill given the size of the investment.

Second, there is no evidence that provision responsive to black and minority ethnic communities has been addressed. Discussion in the course of this study highlighted that many of the generic failings around hospital discharge are magnified within black and minority ethnic communities. Information on 'step-down' or 'step-up' facilities that might be available within an area is rarely circulated. Much greater use should be made, it is suggested, of community-based resources, for example temples and other places of worship, for spreading information. At the same time, activity needs to continue to dispel some of the traditional myths

surrounding particular minority ethnic groups in terms of available support systems and to acknowledge the diversity within all communities. In the absence of specific work on intermediate care, much of the deliberation on the development of culturally sensitive services reported by Patel (1999) for the Royal Commission remains valid.

The third dimension of equality that needs to be part of any ongoing scrutiny of intermediate care is geographical variation, most particularly in remote and rural areas. Rural communities present challenges and opportunities for service provision which apply no less to intermediate care (Wenger, 2001). Indeed it could be argued that certain types of intermediate care, for example 'step-down', may offer particular opportunities in areas where early discharge may not be feasible because an individual lives in a remote location.

Conclusion

The verdict on intermediate care remains uncertain. Glasby (2003) has identified a number of limitations:

- a lack of awareness of roles and responsibilities in other services
- the segregated nature of current professional education, which prevents greater understanding of each other's roles and function
- the lack of co-terminous boundaries between services
- the difficulty of integrating small-scale winter pressures projects into mainstream service provision

- concerns that the NHS and SSDs [*social services departments*] have not spent all the money they have received for intermediate care on the purpose for which it was intended, using it to make up for shortfalls in other services.

(pp. 122–3)

None of these, it will be observed, reflect the perspectives of older people. It should be noted, however, that three national research projects on aspects of intermediate care have been commissioned by the Department of Health and the Medical Research Council and will be reported in 2004. All three of these studies will include exploration of the views and experiences of older people themselves.

A number of key points can be highlighted from the discussions with members of the West of Scotland Seniors Forum:

- Monitoring and supervision of home care staff are essential to promote confidence amongst older people which would make them happy to return home, secure that services would be provided appropriately – older people returning home are seen as potentially vulnerable.
- Concern was expressed that the NHS is emptying beds regardless of whether or not services are available which makes older people very cynical about discharge planning.
- The availability of convalescence/halfway house support was considered important for a number of reasons, including not putting too much pressure on carers when patients are desperate to get home but not really ready and to provide a social environment for recovery.

- Community teams should be well enough resourced for the task at hand.
- Separate convalescence should be provided for those with challenging behaviour.
- Planning should be brought down to the local level as each area is different – this allows local accountability if the service is not being provided appropriately.
- Regulation of domiciliary care should ensure that staff providing these services are well monitored and supervised, although it was recognised that personalities play a big part in how well services are provided.
- Recognition that the roles of the staff involved in domiciliary care had changed over the years and that this reduction in tasks performed, the ‘it’s not my job’ culture, had affected older people’s confidence in home care services.

Without further evidence it is perhaps too soon to draw definitive conclusions on the future of intermediate care. Nonetheless it does appear that evidence is starting to accumulate that the insertion of the additional elements of intermediate care may inhibit rather than encourage the ‘whole system approach’ which is so strongly promoted and may introduce ‘even more complexity and uncertainty into the system’ (Cornes and Clough, 2001, p. 201). With the divergence in policy north and south of the border, at least in terms of terminology, an excellent opportunity presents over the next months for comparative scrutiny. It is critical, however, that the perspectives of older people themselves are retained. If not, delayed discharge solutions may be proposed which pay scant heed to older people themselves.

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