Reading list

Intermediate care and reablement

June 2013

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BOOKS / REPORTS

Pearson, Mark, et al.
National Institute for Health Research
Intermediate care : a realist review and conceptual framework.
SDO Project ; 10/1012/07
Southampton : NIHR, 2013 *Web publication*
This report reviews existing research about the effectiveness and cost-effectiveness of a range of health service changes all of which aim to reduce the need for inpatient hospital care. The main purpose of the review is to develop a conceptual framework that will allow the variety of schemes and their implementation to be better described, and also provide a better basis for explaining variations in their effectiveness and cost-effectiveness.
http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_10-1012-07_V01.pdf
Associated documentation: http://www.netscc.ac.uk/hsdr/projdetails.php?ref=10-1012-07

Social Care Institute for Excellence
Maximising the potential of reablement.
SCIE guide ; 49
London : SCIE, 2013 *Web publication*
This guide is based on research and practice evidence about the effectiveness and cost-effectiveness of reablement.
http://www.scie.org.uk/publications/guides/guide49/files/guide49.pdf
Associated documentation: http://www.scie.org.uk/publications/guides/guide49/index.asp

British Geriatrics Society, et al.
National Audit of Intermediate Care report 2012.
London : NHS Benchmarking Network, 2012 *Web publication*
This is the first report of the National Audit of Intermediate Care presenting findings from data collected in respect of 2011/12. The audit aims to take a whole system view of the effectiveness of intermediate care services and the contribution made to demand management across health and social care systems in England, Wales and Northern Ireland. The audit includes bed and home based intermediate care services provided by a range of health and social care providers including acute trusts, community service providers, local authorities and independent providers. These services are provided in a range of health and social care settings including service users' own homes, general hospitals, community hospitals, nursing and residential care homes.
http://www.nhsbenchmarking.nhs.uk/docs/NAIC_report_20120912.pdf
Associated documentation: http://www.nhsbenchmarking.nhs.uk/icsurvey.aspx

ISBN: 9781909037113
Wood, Claudia and Salter, Jo
Demos
The home cure.
London : Demos, 2012 *Web publication*
This report examines whether, through changes to delivery, out-patient home care programmes can achieve better outcomes. Introduced in the 2000s to reduce "bed-blocking" in hospitals, evidence now suggests that effective reablement can facilitate swifter discharge and reduce the need of ongoing home care support by up to 60 per cent. The savings to both health and social care services are substantial; but in reality performance is patchy. This report finds that reablement services could benefit from deep structural changes to how they are delivered.
http://www.demos.co.uk/files/Home_Cure_-_web_1_.pdf?1340633545

ISBN: 9781905539550
Lees, Liz, editor
Timely discharge from hospital.
Keswick : M&K Publishing : 2012 *HOOX (Lee)*

National Quality Board
How to : organise and run a rapid responsive review : 2012/2013.
[London] : National Quality Board, 2012 *Web publication*
This is one of a number of 'How to' guides issued by the National Quality Board (NQB) which has been designed to help commissioners undertake an appraisal of an organisation or service from a quality perspective. The approach and methodology is primarily designed for use in the acute setting but is sufficiently flexible for application across a range of other clinical and organisational environments such as intermediate care.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/126818/How-to-Organise-and-Run-a-Rapid-Responsive-Review.pdf.pdf
Associated documentation
https://www.gov.uk/government/publications/guides-to-monitoring-quality-during-transition-published

Scottish Government
Maximising recovery and promoting independence : intermediate care's contribution to Reshaping Care : an intermediate care framework for Scotland.
Edinburgh : Scottish Government, 2012 *Web publication*
http://www.scotland.gov.uk/Resource/0038/00386925.pdf
Reshaping Care for Older People:
http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare

Social Care Institute for Excellence
Reablement : implications for GPs and primary care.
At a glance ; 53 (March 2012)
London : SCIE, 2012 *Web publication*
This At a glance briefing focuses on research and practice evidence about reablement and explains the implications for GPs and primary care teams. It also provides a case example demonstrating the advantages of reablement at the individual and service levels.
http://www.scie.org.uk/publications/ataglance/ataglance53.pdf

Social Care Institute for Excellence
Reablement : key issues for commissioners of adult social care.
At a glance ; 52 (March 2012)
London : SCIE, 2012 *Web publication*
This At a glance briefing outlines research and practice evidence about reablement and describes what is required for successful implementation. It provides links to evidence and information freely available online and presents two case examples of the impact reablement can have on the population and on local authority budgets.
http://www.scie.org.uk/publications/ataglance/ataglance52.pdf

Bridges, Ed and James, Vicki
WRVS
Getting back on your feet : reablement in Wales.
Cardiff : WRVS, 2012
This report looks at the provision of reablement services across Wales, and seeks to examine the extent to which different local authorities and health boards across Wales have developed reablement provision.
http://www.wrvs.org.uk/Uploads/Documents/Reports%20and%20Reviews/getting_back_on_your_feet_reablement_in_wales_report.pdf

Pitts, Jenny, et al.
Ambrey Associates and Helen Sanderson Associates
A new reablement journey
Shrewsbury : Ambrey Associates, 2011 *Web publication*
http://www.helensandersonassociates.co.uk/media/52374/reablementfinalreport.pdf
Associated documentation:
http://www.helensandersonassociates.co.uk/reading-room/how/person-centred-thinking/reablement.aspx

Stringfellow, Rachel and Leeming, James
Adult Care Services Bury and NHS Bury
A business case for the re-ablement pathway.
Bury : [Bury Primary Care Trust] 2011 *Web publication*
This business case aims to show the level of resources in Bury that are currently committed to care services for vulnerable adults experiencing either a sudden or steady deterioration in their ability to live independently. The reablement model is a proposed model of care that integrates Health and Social teams together under one pathway.
http://www.buryccg.nhs.uk/Library/Board_Papers/2011/AI%205.0%20appendix%201%20business%20case%20020211.pdf

Research in Practice for Adults
Reablement : policy, research and practice.
Totnes, Devon : Ripfa, 2011 *Web publication*
Reablement is a key policy priority for health and social care in increasing independence, reducing costs and promoting partnership work. This briefing examines the evidence around reablement in terms of the implications for practice and has identified the main areas that local authorities need to consider.
http://www.ripfa.org.uk/onetoone/casestudies/doc_download/623-reablement-briefing

Francis, Jennifer, et al.
Social Care Institute for Excellence
Reablement : a cost-effective route to better outcomes.
Research briefing ; 36 (April 2011)
London : SCIE, 2011 *Web publication*
This research briefing looks at the issues surrounding reablement, including various definitions, why it is important and the organisational implications. It also summarises what other research has shown.
http://www.scie.org.uk/publications/briefings/files/briefing36.pdf
Associated documentation http://www.scie.org.uk/publications/briefings/index.asp

Great Britain. Department of Health
Ready to go? : planning the discharge and the transfer of patients from hospital and intermediate care.
London : DH, 2010 *Web publication*
This publication provides good practice guidelines for health and social care professionals.
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116675.pdf

Nancarrow, Susan A., et al.
Sheffield Hallam University. Centre for Health and Social Care Research, et al.
The relationship between workforce flexibility and the costs and outcomes of older peoples' services.
SDO Project ; 08/1519/95
Leeds : NIHR SDO, 2010 *Web publication*
The purpose of this research is to examine how, and with what impact, workforce substitution and specialisation is influenced by workforce change policies in the context of older peoples' services. The specific setting for this research is community and intermediate care services (CAICS) for older people.
http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1519-95_V01.pdf
Associated documentation: http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1519-95

Allen, Kerry and Glasby, Jon
University of Birmingham. Health Services Management Centre
'The billion dollar question' : embedding prevention in older people's services : 10 'high impact' changes.
HSMC policy paper ; 8 (August 2010)
Birmingham : HSMC, 2010 *Web publication*
This paper reviews emerging evidence around prevention in older people's services. It identifies and reviews ten high impact changes covering: promoting healthy lifestyles; vaccination; screening; falls prevention; housing adaptations and practical support; telecare and technology; intermediate care; re-ablement; partnership working; and, personalisation
http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/PolicyPapers/Policy-paper-8.pdf

ISBN: 9781907265082
Glendinning, Caroline, et al.
University of York. Social Policy Research Unit and University of Kent. Personal Social Services Research Unit
Home care re-ablement services :investigating the longer-term impacts (prospective longitudinal study).
Working paper ; DHR 2438
York : SPRU, 2010 *HOOZ (Uni)*
Re-ablement is a new, short-term intervention in English home care. It helps users to regain confidence and relearn self-care skills and aims to reduce needs for longer-term support. This research examined the immediate and longer-term impacts of home care re-ablement, the cost-effectiveness of the service, and the content and organisation of re-ablement services. People who received home care re-ablement were compared with a group receiving conventional home care services, both groups were followed for up to one year.
http://www.york.ac.uk/inst/spru/research/pdf/Reablement.pdf
Associated documentation http://php.york.ac.uk/inst/spru/pubs/1882/

Griffiths, Peter D., et al.
The Cochrane Collaboration. Cochrane Effective Practice and Organisation of Care Group
Effectiveness of intermediate care in nursing-led in-patient units.
Oxford : John Wily & Sons, 2009 *Web publication*
Cochrane Database of Systematic Reviews ; 2007 Issue 2. Art. No.: CD002214. DOI: 10.1002/14651858.CD002214.pub3
The review aims to determine whether nursing-led inpatient units are effective in preparing patients for discharge from hospital. Effectiveness of the NLU will be compared to 'usual care' (inpatient care in general acute hospital wards).
http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002214.pub3/full

Housing Learning & Improvement Network
Short stay intermediate care services in a range of housing and care settings.
London : LIN, 2009
Housing LIN ; factsheet 31
http://www.dhcarenetworks.org.uk/_library/Resources/Housing/Support_materials/Factsheets/Factsheet_31_Intermediate_Care.pdf

Lloyd-Jones, Angie
Scottish Borders. Social Work Services and NHS Borders
Waverley Intermediate Care Pilot : final evaluation report.
Edinburgh : [Joint Improvement Team], 2009 *Web publication*
The shared principles of Changing Lives (Scottish Executive, 2006) and Delivering for Health (Scottish Executive, 2005) direct a shift in the way that services are delivered, with a greater emphasis on self care and independent living. The reports identify the need for change in the ways that services are delivered, with shifts to inter-agency service redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling.
http://www.jitscotland.org.uk/downloads/1280140403-IC_Evaluation_Report_FINAL_COPY_Short_Version_04-06-09.pdf

ISBN: 9781871713596
Jones, Karen C., et al.
University of York. Social Policy Research Unit
The short-term outcomes and costs of home care re-ablement services.
Working paper ; DHR 2378
York : SPRU, 2009 *Web publication*
This report concentrates on one aspect of the evaluation, namely the immediate benefits of home care re-ablement. Specifically, its aims are: 1. To provide robust research evidence on the immediate benefits of home care re-ablement, in terms of improved independence, quality of life and perceived health; 2. To describe the costs of home care re-ablement services; 3. To explore the characteristics of re-ablement service users and of re-ablement service interventions themselves that are associated with service user well-being, quality of life and social care outcomes.
http://www.york.ac.uk/inst/spru/research/pdf/ReablementOutcomes.pdf

British Geriatrics Society
Intermediate care : guidance for commissioners and providers of health and social care. Revised edition ; February 2008
London : British Geriatrics Society, 2008 *Web publication*
Compendium document ; 4.2
http://www.bgs.org.uk/index.php?option=com_content&view=article&id=363:intermediatecare&catid=12:goodpractice&Itemid=106

ISBN: 9781904114772
Royal College of Nursing
Maximising independence : the role of the nurse in supporting the rehabilitation of older people.
London : RCN, 2007 *Web publication*
http://www.rcn.org.uk/__data/assets/pdf_file/0003/109326/003186.pdf

Barton, Pelham, et al.
University of Birmingham. Health Services Management Centre, et al.
A national evaluation of the costs and outcomes of intermediate care services for older people : final report.
Leicester : Leicester Nuffield Research Unit, 2006 *HOAC:QHA (Bar)*
Executive summary:
http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/research/intermediate-care-older-people.pdf

Care Services Improvement Partnership
Great Britain. Department of Health
Everybody's business : integrated mental health services for older adults : a service development guide.
[London] CSIP, 2005 *IJH:QHA (Car)*
Summary: http://www.nmhdu.org.uk/silo/files/six-key-messages.pdf

Godfrey, Mary, et al.
University of Leeds. Institute of Health Sciences and Public Health Research. Centre for Health and Social Care.
An evaluation of intermediate care for older people : final report.
Leeds : University of Leeds, 2005 *HOAC:QHA (God)*

ISBN: 187048066X
Hague, John and Cohen, Alan
Sainsbury Centre for Mental Health
The neglected majority : developing intermediate mental health care in primary care.
London : Sainsbury Centre for Mental Health, 2005 *HMP:QY (Hag)*
http://www.centreformentalhealth.org.uk/pdfs/Neglected_majority_report.pdf

Lane, Robyn
Homeless Intermediate Care Steering Group
The road to recovery : a feasibility study into homeless intermediate care.
London : UK Coalition of Older Homelessness, 2005 *QAI (Lan)*
http://www.housinglin.org.uk/_library/Resources/Housing/Housing_advice/The_Road_to_Recovery_-_A_feasibility_study_into_homelessness_and_intermediate_care_December_2005.pdf

ISBN: 1405120339
Roe, Brenda and Beech, Roger, editors
Intermediate and continuing care : policy and practice.
Oxford : Blackwell Publishing, 2005 *HOAC (Roe)*

ISBN: 0102920621
Great Britain. National Audit Office
Ensuring the effective discharge of older patients from NHS acute hospitals.
London : Stationery Office, 2003 *HOOX:QHA (Gre)*
House of Commons papers. Session 2002-03 ; 392
http://www.nao.org.uk/wp-content/uploads/2003/02/0203392.pdf
Associated documentation:
http://www.nao.org.uk/report/ensuring-the-effective-discharge-of-older-patients-from-nhs-acute-hospitals/

ISBN: 0215011864
Great Britain. Parliament. House of Commons. Committee of Public Accounts
Leigh, Edward, Chairman
Ensuring the effective discharge of older patients from NHS acute hospitals : thirty-third report of session 2002-03 : report, together with formal minutes, oral and written evidence.
London : Stationery Office, 2003 *HOOX:QHA (Gre)*
House of Commons papers. Session 2002-03 ; 459
http://www.publications.parliament.uk/pa/cm200203/cmselect/cmpubacc/459/459.pdf

ISBN: 1857174666
Stevenson, Jan and Spencer, Linda
Developing intermediate care : a guide for health and social service professionals.
London : King's Fund, 2002 *HOAC (Ste)*
http://www.kingsfund.org.uk/sites/files/kf/Developing-Intermediate-Care-guide-health-social-services-professionals-Jan-Stevenson-Linda-Spencer-The-Kings-Fund-July-2009.pdf

ISBN: 1857174542
Stevenson, Jan
Mapping local rehabilitation and intermediate care services : a whole systems approach to understanding service capacity and planning change.
London : King's Fund, 2001 *QBFR (Ste)*
http://www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services

Wilson, Keith and Stevenson, Jan
Intermediate care coordination : the function : paper prepared for the workshop 'Intermediate care coordinators : exploring the role' 20 July 2001, King's Fund.
London : King's Fund, 2001 *HOAC (Wil)*

ISBN: 1857172736
Vaughan, Barbara and Lathlean, Judith
Intermediate care : models in practice.
London : King's Fund, 1999 *HOAC (Vau)*
http://www.kingsfund.org.uk/publications/intermediate-care

JOURNAL ARTICLES

Carlisle, Daloni
Time to go back to the 3Rs.
Health Service Journal 2013; 123 (6354): 14-15 (7 June 2013 Suppl.)
Integrating recovery, reablement and rehabilitation will be key to cutting hospital readmissions. By Daloni Carlisle. [Introduction]
http://www.hsj.co.uk/Journals/2013/06/06/f/s/x/HSJ_COMMISSIONINGSUPP_130607.pdf

You're not on your own.
Health Service Journal 2013; 123 (6354): 16-17 (7 June 2013 Suppl.)
Innovative ways to prevent health problems include using technology to reach out to isolated elderly people and a rethink of traditional home from hospital services. [Introduction]
http://www.hsj.co.uk/Journals/2013/06/06/f/s/x/HSJ_COMMISSIONINGSUPP_130607.pdf

Moore, Alison
More than just a bed.
Health Service Journal 2013; 123 (6354): 22-23 (7 June 2013 Suppl.)
Commissioners are looking at placing frail patients in care homes- with a full care package. [Introduction]
http://www.hsj.co.uk/Journals/2013/06/06/f/s/x/HSJ_COMMISSIONINGSUPP_130607.pdf

Johannessen, Anne-Kari, et al.
The role of an intermediate unit in a clinical pathway.
Journal of Integrated Care 2013 13 (26 March 2013)
INTRODUCTION: Different care models have been established to achieve more coordinated clinical pathways for older patients in the transition between hospital and home. This study explores an intermediate unit's role in a clinical pathway for older patients with somatic diseases. THEORY AND METHODS: Qualitative data were collected via interviews, observations, and a questionnaire. Participants included patients and healthcare providers within both specialist and primary healthcare. Transcripts of interviews and field notes were analyzed using a method of systematic text condensation. RESULTS: Healthcare providers in the hospital, the intermediate unit, and the municipalities have different opinions about who is a "suitable" patient for the unit and what is the proper time for hospital discharge. This results in time-consuming negotiations between the hospital and the unit. Incompatible computer systems increase the healthcare provider's workload. Several informants are doubtful as to whether a stay in the unit is useful to the patients, while the patients are mostly pleased with their stay and the transferral. CONCLUSION AND DISCUSSION: This study describes challenges that may occur when a new unit is established in an existing healthcare system in order to achieve an appropriate clinical pathway from hospital to home. [Abstract]
http://www.ijic.org/index.php/ijic/article/view/859/1983

Miettinen, Sari, et al.
Talking about the institutional complexity of the integrated rehabilitation system : the importance of coordination.
Journal of Integrated Care 2013; 13 (22 March 2013)
Rehabilitation in Finland is a good example of functions divided among several welfare sectors, such as health services and social services. The rehabilitation system in Finland is a complex one and there have been many efforts to create a coordinated entity. The purpose of this study is to open up a complex welfare system at the upper policy level and to understand the meaning of coordination at the level of service delivery. We shed light in particular on the national rehabilitation policy in Finland and how the policy has tried to overcome the negative effects of institutional complexity. In this study we used qualitative content analysis and frame analysis. As a result we identified four different welfare state frames with distinct features of policy problems, policy alternatives and institutional failure. The rehabilitation policy in Finland seems to be divided into different components which may cause problems at the level of service delivery and thus in the integration of services. Bringing these components together could at policy level enable a shared view of the rights of different population groups, effective management of integration at the level of service delivery and also an opportunity for change throughout the rehabilitation system. [Abstract]
http://www.ijic.org/index.php/ijic/article/view/851/1972

Hall, C., et al.
Can post-acute care programmes for older people reduce overall costs in the health system? : a case study using the Australian Transition Care Programme.
Health and Social Care in the Community 2012; 20 (1): 97-102 (January 2012)
There is an increasing demand for acute care services due in part to rising proportions of older people and increasing rates of chronic diseases. To reduce pressure and costs in the hospital system, community-based post-acute care discharge services for older people have evolved as one method of reducing length of stay in hospital and preventing readmissions. However, it is unclear whether they reduce overall episode cost or expenditure in the health system at a more general level. In this paper, we review the current evidence on the likely costs and benefits of these services and consider whether they are potentially cost-effective from a health services perspective, using the Australian Transition Care Programme as a case study. Evaluations of community-based post-acute services have demonstrated that they reduce length of stay, prevent some re-hospitalisations and defer nursing home placement. There is also evidence that they convey some additional health benefits to older people. An economic model was developed to identify the maximum potential benefits and the likely cost savings from reduced use of health services from earlier discharge from hospital, accelerated recovery, reduced likelihood of readmission to hospital and delayed entry into permanent institutional care for participants of the Transition Care Programme. Assuming the best case scenario, the Transition Care Programme is still unlikely to be cost saving to a healthcare system. Hence for this service to be justified, additional health benefits such as quality of life improvements need to be taken into account. If it can be demonstrated that this service also conveys additional quality of life improvements, community-based programmes such as Transition Care could be considered to be cost-effective when compared with other healthcare programmes. [Abstract]

Black, Michelle and Glaves, Gemma
Integrated stratigies will work best.
Pharmaceutical Journal 2011; 287 (7683): 698 (10 December 2011)
Michella Black and Gemma Glaves have evaluated pharmacy interventions in Sheffield and it appears that medicines optimisation is best when health and social care work together. [Introduction]

Manthorpe, Jill
Long-term impact of home care reablement.
Community Care 2011; 1880 32-33 (13 October 2011)
Reablement is popular with service users and although not the cheapest option, may have longer term benefits. [Abstract]
http://www.communitycare.co.uk/articles/11/10/2011/117565/benefits-of-home-care-reablement-in-the-long-term.htm

Rabiee, Parvaneh and Glendinning, Caroline
Organisation and delivery of home care re-ablement: what makes a difference?
Health and Social Care in the Community 2011; 19 (5): 495-503 (September 2011)
Home-care re-ablement or 'restorative' services are a cornerstone of preventive service initiatives in many countries. Many English local authorities are transforming their former in-house home-care services to provide intensive, short-term re-ablement instead. The focus of this paper is on the organisation and content of re-ablement services and the features of their organisation and delivery that have the potential to enhance or detract from their effectiveness. Qualitative data were collected from five sites with well-established re-ablement services. Data included semi-structured interviews with senior service managers in each site, observation of 26 re-ablement visits to service users across the five sites (four to six in each site) and a focus group discussion with front-line staff in each site (in total involving 37 front-line staff). The data generated from all three sources were analysed using the framework approach. All five services had developed from selective pilot projects to inclusive 'intake' service, accepting almost all referrals for home-care services. A number of features were identified as contributing to the effectiveness of re-ablement services. These included: service user characteristics and expectations, staff commitment, attitudes and skills, flexibility and prompt intervention, thorough and consistent recording systems, and rapid access to equipment and specialist skills in the team. Factors external to the re-ablement services themselves also had implications for their effectiveness, these included: a clear, widely understood vision of the service, access to a wide range of specialist skills, and capacity within long-term home-care services. The paper argues that re-ablement can be empowering for all service users in terms of raising their confidence. However, the move to a more inclusive 'intake' service suggests that outcomes are likely to be considerably lower for service users who have more limited potential to be independent. The paper discusses the implications for practice. [Abstract]

Mur-Veeman, Ingrid and Govers, Mark

Buffer management to solve bed-blocking in the Netherlands 2000–2010 : cooperation from an integrated care chain perspective as a key success factor for managing patient flows.

International Journal of Integrated Care 2011; 11 (25 July 2011)

INTRODUCTION: Bed-blocking problems in hospitals reflect how difficult and complex it is to move patients smoothly through the chain of care. In the Netherlands, during the first decade of the 21st century, some hospitals attempted to tackle this problem by using an Intermediate Care Department (ICD) as a buffer for bed-blockers. However, research has shown that ICDs do not sufficiently solve the bed-blocking problem and that bed-blocking is often caused by a lack of buffer management. TOOL: Buffer management (BM) is a tool that endeavors to balance patient flow in the hospital to nursing home chain of care. RESULTS: Additional research has indicated that the absence of BM is not the result of providers' thinking that BM is unnecessary, unethical or impossible because of unpredictable patient flows. Instead, BM is hampered by a lack of cooperation between care providers. CONCLUSION: Although stakeholders recognize that cooperation is imperative, they often fail to take the actions necessary to realize cooperation. Our assumption is that this lack of willingness and ability to cooperate is the result of several impeding conditions as well as stakeholders' perceptions of these conditions and the persistence of their current routines, principles and beliefs (RPBs). DISCUSSION: We recommend simultaneously working on improving the conditions and changing stakeholders' perceptions and RPBs. [Abstract]

http://www.ijic.org/index.php/ijic/article/viewArticle/650/1374

Nazarko, Linda

Care closer to home : aspirations and delivery.

British Journal of Healthcare Management 2011; 17 (4): 145-151 (April 2011)

Although successive governments have aspired to provide care closer to home there's still a gap between aspiration and delivery. In their report the Audit Commission produced a report that stated 'PCTs made little or no in-road in 2008/09 to transferring care from hospitals into the community.' (Audit Commission, 2009). This article analyses the reasons why intermediate care services are not being fully utilised and sets out the case for increased investment in intermediate care services. [Abstract]

Hutchinson, Tom, et al.

National pilot audit of intermediate care.

Clinical Medicine 2011; 11 (2): 146-149 (April 2011)

The National Service Framework for Older People resulted in the widespread introduction of intermediate care (IC) services. However, although these services have shared common aims, there has been considerable diversity in their staffing, organisation and delivery. Concerns have been raised regarding the clinical governance of IC with a paucity of data to evaluate the effectiveness, quality and safety of these services. This paper presents the results of a national pilot audit of IC services focusing particularly on clinical governance issues. The results confirm these concerns and provide support for a larger scale national audit of IC services to monitor and improve care quality. [Abstract]

Dickinson, Helen and Neal, Colette

Single point of access to third sector services : the Conwy Collaborative approach.

Journal of Integrated Care 2011; 19 (2): 37-48 (April 2011)

The need for joint working between statutory and non-statutory bodies is an important component of policy across the UK. While it is something that governments push for, it has not always been delivered effectively in practice. This paper reports on a project that sought to bring together statutory, voluntary and community sector bodies to help improve and strengthen the planning and commissioning of services from the third sector to support health and social care needs. The model was intended to provide planners with a single reference point for procurement of service packages from a combination of statutory, independent and third-sector organisations for specific regional and local service-user groups. We report on the experience of the first 18 months of this project, indicating that the project has been highly successful in the eyes of a range of stakeholders. Stakeholders from a range of backgrounds were far more positive about the experience than the literature would predict to be the case. Outcomes monitoring suggests that service users were far more independent and had seen improvements on a range of dimensions. The paper finishes by formulating suggestions for the factors which seem to have contributed to its success. [Abstract]

Fox, Alex

A new model for care and support : sharing lives and taking charge.

Working with Older People 2011; 15 (2): 58-63

PURPOSE: This paper aims to look at lesser-known approaches to working with older people which challenge current assumptions about older people and approaches to providing care, suggesting that they lay on a continuum of support services, which stretches from traditional, paid-by-the-hour, professional/client transactions at one end, to unboundaried, unpaid family care at the other. DESIGN/METHODOLOGY/APPROACH: The paper looks at Shared Lives, ASA Lincolnshire's At Home Day Resource for people with dementia, Homeshare, KeyRing and micro-enterprises. FINDINGS: Through combining the value of real relationships with more formal support approaches, better outcomes can be achieved at lower costs. ORIGINALITY/VALUE: With the gap between the capacity of existing services and the needs of an ageing population growing daily, this paper provides additional research and development in this area of work. [Abstract]

Dent, Emma

In and out and getting about.

Health Service Journal 2011; 121 (6246): 26-27 (3 March 2011)

A third sector scheme helps service users return home from hospital sooner and resume their daily activities – and it helps to avoid admissions, says Emma Dent. [Introduction]

Mitchell, Fraser, et al.

Intermediate care : lessons from a demonstrator project in Fife.

Journal of Integrated Care 2011; 19 (1): 26-36 (February 2011)

This article reports on the experiences and outcomes of a demonstrator project in Fife aimed at improving intermediate care services. The project focused on three strands: workforce development, extended access and pharmacy. The outcomes provide valuable information to guide future developments in intermediate care services. [Abstract]

Hughes, Mark

Getting the best out of student placements.

Nursing Times 2011; 107 (2): 18-19 (18 January 2011)

Negative feedback from student nurses about intermediate care placements led to a focus group being set up to look at why they were viewed negatively and what could be done to improve students' experiences. This article discusses the outcome of the focus group, and gives guidance on how to ensure students get the most out of intermediate care placements. [Abstract]

Lloyd-Jones, Angie

Redesigning a local authority residential care home to provide an intermediate care resource.

Journal of Care Services Management 2010; 4 (4): 286-294 (September 2010)

Key national policy drivers have identified the need for change in the way that services are delivered, with shifts to interagency redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling. A redesign of a wing of a Scottish Borders local authority residential care home to provide an intermediate care resource was carried out in 2008-09 and fully evaluated. This paper presents the main findings of the evaluation and concludes that the redesign has demonstrated an effective model that can be a transferable framework to deliver intermediate care in other residential care homes. [Abstract]

Madaras, Andrew and Hilton, Claire

Developing an intermediate care unit for older people with mental and physical illnesses.

Nursing Times 2010; 106 (30): 18-19 (3 August 2010)

Intermediate care is an integral part of healthcare for older people with mental and physical illnesses. It can provide rehabilitation and enable early hospital discharge, but people with both mental and physical illnesses have frequently been excluded from intermediate care services. This article describes a twelve bed, nurse led rehabilitation unit for older people with mental and physical health needs. The ethos is to promote independence and allow patients to achieve their objectives no matter what their age and ongoing limitations. [Abstract]

Dixon, Simon, et al.

The relationship between staff skill mix, costs and outcomes in intermediate care services.

BMC Health Services Research 2010; 10 (221): (29 July 2010)

BACKGROUND: The purpose of this study was to assess the relationship between skill mix, patient outcomes, length of stay and service costs in older peoples' intermediate care services in England. METHODS: We undertook multivariate analysis of data collected as part of the National Evaluation of Intermediate Care Services. Data were analysed on between 337 and 403 older people admitted to 14 different intermediate care teams. Independent variables were the numbers of different types of staff within a team and the ratio of support staff to professionally qualified staff within teams. Outcome measures include the Barthel index, EQ-5D, length of service provision and costs of care. RESULTS: Increased skill mix (raising the number of different types of staff by one) is associated with a 17 per cent reduction in service costs (p = 0.011). There is weak evidence (p = 0.090) that a higher ratio of support staff to qualified staff leads to greater improvements in EQ-5D scores of patients. CONCLUSIONS: This study provides limited evidence on the relationship between multidisciplinary skill mix and outcomes in intermediate care services. [Abstract]

http://www.biomedcentral.com/content/pdf/1472-6963-10-221.pdf

Mitchell, Fraser, et al.

Hospital discharge : a descriptive study of the patient journey for frail older people with complex needs.

Journal of Integrated Care 2010; 18 (3): 30-36 (June 2010)

This paper reports on a descriptive study using locally available health and social care data relating to the patient journey of a cohort of frail, older people with complex health and social care needs. The study identifies contact with social care services and some health services prior to hospital admission, charts the patient journey in hospital, and provides information on discharge destinations. The findings have implications for the discharge planning process and the improvement of community care services, including intermediate care. [Abstract]

Lees, Liz

Exploring the principles of best practice discharge to ensure patient involvement.

Nursing Times 2010; 106 (25): 10-13 (29 June 2010)

Recent guidance [Ready to go? : planning the discharge and the transfer of patients from hospital and intermediate care', Department of Health, 2010] features ten practical steps to improve the process of patient discharge and transfer – one of the eight high impact actions for nursing and midwifery. This article examines the current policy context surrounding discharge in the health service, and gives practical advice on implementing the ten steps. For each step the Lean methodology has been used. According to the NHS Institute for Innovation and Improvement, Lean is an improvement approach to improve flow and eliminate waste, developed by Toyota. The principles discussed in this article should help hospital trusts to apply a systematic approach to the discharge planning process and prevent readmissions while improving the quality of patient discharge. [Abstract]

Woodford, Henry J. and George, James

Intermediate care for older people in the UK.

Clinical Medicine 2010; 10 (2): 119-123 (April 2010)

Intermediate care (IC) has been government policy for implementation in the UK for almost ten years. It was hoped that it would help free up acute hospital resources. However, admission rates continue to rise and are rising fastest in those over the age of 75. Many different models of IC have been tried. Typically, outcomes are very similar to traditional hospital care and they tend to be met with high patient satisfaction. Yet there is no evidence that they reduce acute hospital use or that they are cost efficient. Maybe it is time to rethink our national strategy on this issue? [Abstract]

Nancarrow, Susan A., et al.
Understanding service context : development of a service pro forma to describe and measure elderly peoples' community and intermediate care services.
Health and Social Care in the Community 2009; 17 (5): 434-446 (September 2009)
The purpose of this paper was to develop a pro forma which classifies the components of service delivery and organization which may impact on the outcomes of elderly peoples' community and intermediate care services. The resulting analytic template provides a basis for comparison between services and may help guide service commissioning and development. A qualitative approach was used in which key evaluations and reports were selected on the basis that they described elderly peoples' community and intermediate care services. These were analysed systematically using a qualitative (template) approach to draw out the key themes used to describe services. Themes were then structured hierarchically into an analytic template. Seventeen key documents were analysed. The initial coding framework classified 334 themes describing intermediate care services. These items were then clustered into 78 categories, which were reduced to 17 subcategories, then six overall groupings to describe the services, namely; (1) context; (2) reason for the service; (3) service-users; (4) access to the service; (5) service structure; and (6) the organization of care. The resulting analytic template has been developed into a 'service pro forma' which can be used as a basis to describe and compare a range of services. We propose that all service evaluations should describe, in detail, their context in a comparable way, so that other services can learn from and/or apply the findings from these studies. 1 fig. 2 tables 26 refs. [Abstract]

Gomersall, Caroline
A rapid response intermediate care service for older people with mental health problems.
Nursing Times 2009; 105 (17): 12-13 (5 May 2009)
This article follows the development of an intermediate care service for older people with mental health needs and assesses the impact of the service on patients, carers and referrers, and the availability of dedicated elderly mentally ill (EMI) beds. 3 refs. [Abstract]

Robinson, Jennifer
Facilitating earlier transfer of care from acute stroke services into the community.
Nursing Times 2009; 105 (12): 12-13 (31 March 2009)
This article outlines an initiative to reduce length of stay for stroke patients within an acute hospital and to facilitate earlier transfer of care. Existing care provision was remodelled and expanded to deliver stroke care to patients within a community bed-based intermediate care facility or intermediate care at home. This new model of care has improved the delivery of rehabilitation through alternative and innovative ways of addressing service delivery that meet the needs of the patients. 6 refs. [Abstract]

Davis, Rowenna
Home advantage.
Community Care 2009; (1753): 28-29 (15 January 2009)
Short-term care plans in Wales are reducing pressure on hospital beds by allowing older people to receive medical treatment in their own homes, writes Rowenna Davis. [Introduction]
http://www.communitycare.co.uk/Articles/14/01/2009/110397/Torfaen-service-treats-older-people-at-home-rather-than-in.htm

Kaambwa, Billingsley, et al.

Costs and health outcomes of intermediate care : results from five UK case study sites.

Health and Social Care in the Community 2008; 16 (6): 573-581 (December 2008)

The objectives of this study were to explore the costs and outcomes associated with different types of intermediate care (IC) services, and also to examine the characteristics of patients receiving such services. Five UK case studies of 'whole systems' of IC were used, with data collected on a sample of consecutive IC episodes between January 2003 and January 2004. Statistical differences in costs and outcomes associated with different IC services and patient groups were explored. Factors associated with variation in IC episode outcomes (EuroQol EQ-5D and Barthel Index) were explored using an econometric framework. Data were available for 2253 episodes of IC. In terms of Department of Health criteria, a large proportion of patients (up to 47 per cent of those for whom data were available) in this study were inappropriately admitted to IC services. As regards service function, compared to supported discharge, admission avoidance services were associated with both lower costs and greater health and functional gains. These gains appear to be driven, in part, by illness severity (more dependent patients tended to gain most benefit). In addition, these gains appear to be larger where the admission was appropriate. Our work suggests a need for the development and application of robust and reliable clinical criteria for admission to IC, and close co-operation between hospital and community service providers over selection of patients and targeting of IC and acute care services to meet defined clinical need. 6 tables 41 refs. [Abstract]

Regen, Emma, et al.

Challenges, benefits and weaknesses of intermediate care : results from five UK case study sites.

Health and Social Care in the Community 2008; 16 (6): 629-637 (December 2008)

The authors explore the views of practitioners and managers on the implementation of intermediate care for elderly people across England, including their perceptions of the challenges involved in its implementation, and their assessment of the main benefits and weaknesses of provision. Qualitative data were collected in five case study sites (English primary care trusts) via semistructured interviews (n=61) and focus group discussions (n=21) during 2003 to 2004. Interviewees included senior managers, intermediate care service managers, clinicians and health and social care staff involved in the delivery of intermediate care. The data were analysed thematically using an approach based on the 'framework' method. Workforce and funding shortages, poor joint working between health and social care agencies and lack of support/involvement on the part of the medical profession were identified as the main challenges to developing intermediate care. The perceived benefits of intermediate care for service-users included flexibility, patient centredness and the promotion of independence. The 'home-like' environment in which services were delivered was contrasted favourably with hospitals. Multidisciplinary teamworking and opportunities for role flexibility were identified as key benefits by staff. Insufficient capacity, problems of access and awareness at the interface between intermediate care and 'mainstream' services combined with poor co-ordination between intermediate care services emerged as the main weaknesses in current provision. Despite reported benefits for service-users and staff, the study indicates that intermediate care does not appear to be achieving its full potential for alleviating pressure within health and social care systems. The strengthening of capacity and workforce, improvements to whole systems working and the promotion of intermediate care among doctors and other referrers were identified as key future priorities. 2 tables 32 refs. [Abstract]

Glasby, Jon, et al.

Older people and the relationship between hospital services and intermediate care : results from a national evaluation.

Journal of Interprofessional Care 2008; 22 (6): 639-649 (December 2008)

In the UK, new intermediate care services have been established to prevent unnecessary hospital admissions, facilitate effective discharge and prevent premature care home admissions. This paper reports findings from a national evaluation of intermediate care, focusing on the relationship between hospital services and intermediate care. Participants included key managers and practitioners involved in the planning, management and delivery of intermediate care in five case study sites. During the study, they identified a range of tensions between hospital services and intermediate care, including concerns about the role and involvement of acute clinicians; the safety, quality and appropriateness of intermediate care; access to and eligibility for intermediate care; a lack of understanding and awareness of intermediate care; and the risk of intermediate care being dominated by acute pressures. Although participants were able to identify several practical ways forward, resolving such fundamental tensions seems to require significant and long-term cultural change in the relationship between acute and intermediate care. Overall, this study raises questions about the extent to which intermediate care will be able to rebalance the current health and social care system and make a substantial contribution to tackling ongoing concerns about emergency hospital admissions and delayed transfers of care. 3 figs. 19 refs. [Abstract]

Glendinning, Caroline and Newbronner, Elizabeth

The effectiveness of home care reablement : developing the evidence base.

Journal of Integrated Care 2008; 16 (4): 32-39 (August 2008)

Adult social care services are increasingly establishing reablement services as part of their range of home care provision, sometimes alone, sometimes jointly with NHS partners. Typically, home care reablement is a short-term intervention, often free of charge, that aims to maximise independent living skills. This paper describes two small studies examining the impact of home care reablement on subsequent service use. The evidence so far strongly suggest that a period of home care reablement can reduce the subsequent use of home care services and that, for some people, these benefits may last for a year or more. However, a number of organisational and cultural factors can limit the immediate and longer-term benefits of home care reablement. 8 figs. 2 tables 11 refs. [Abstract]

Benten, Jane and Spalding, Nicola J

Intermediate care : what are service users' experiences of rehabilitation?

Quality in Ageing 2008; 9 (3): 4-14 (September 2008)

The Department of Health's introduction of intermediate care recognised the need for rehabilitation following acute hospital care. The importance of rehabilitation was also stressed by a review carried out across England and Wales by District Audit. This article reports a phenomenological study carried out to explore service users' experiences of a 22-bedded intermediate care service. Face-to-face, semi-structured interviews were conducted with eight service users who were older people, with a further follow-up interview two weeks later. Data was analysed using an open-coding and theming approach. One of the six emergent themes is discussed in this article: service users' rehabilitation experiences. Data was themed into a rehabilitation framework of users' understanding, assessment and goal setting, interventions and transfer home. Intermediate care was found to provide support for service users between discharge from acute hospital and return to their own homes, but service users lacked understanding and awareness of the potential of the intermediate care service. They did not feel involved in their assessment and goal setting and so were unable to make individual contributions regarding their own rehabilitation needs. Interventions were subsequently not linked to their needs and transfer home experiences were variable. Users' experiences did not reflect the Department of Health's four principles that underpin the delivery of intermediate care: person-centred care; whole system working; timely access to specialist care; promoting health and an active life. Recommendations are made to address these and to incorporate the recommendations from District Audit. 35 refs. [Abstract]

Sutton, Lynette and Dalley, Jayne

Reflection in an intermediate care team.

Physiotherapy 2008; 94 (1): 63-70 (March 2008)

OBJECTIVES: Reflection has been cited as an effective method of providing evidence of professional development, learning and continued competence. Reflection in teams is thought to develop trust within the team and greater understanding of other team members' roles and responsibilities. The aim of this qualitative study was to describe the experiences and perceptions of reflection by members of an intermediate care team. DESIGN: Phenomenological design, consisting of individual semi-structured audio-taped interviews. The interviews were transcribed and read to gain understanding. Themes were identified and grouped into categories. PARTICIPANTS: Ten members of a multidisciplinary intermediate care team were interviewed. FINDINGS: Team reflection had not been developed formally in the intermediate care team, although many of the prerequisites for team reflection were present. Team members primarily used dialogical reflection in clinical practice as a problem-solving tool. Written reflection was limited, with its use being dependent on the skills, level of training and post qualification support of the participants. CONCLUSION: A formal structure and managerial support is necessary to facilitate team reflection. Additional postgraduate support is required to enable team members to utilise written reflection effectively. Further research to investigate reflection in health and social care teams is warranted. 1 fig. 56 refs. [Abstract]

Hibberd, Jane

The home-visiting process for older people in the in-patient intermediate care services.

Quality in Ageing 2008; 9 (1): 13-23 (March 2008)

Older people account for a significant proportion of users of health and social care services (Wanless, 2006). Within current constraints on health and social care services, it is essential that interventions such as home visits for older people can be seen to be appropriately deployed resources for facilitating their safe and timely discharge home. This paper discusses the findings of an evaluation project undertaken in 2003/04 within two in-patient intermediate care services. The service provided short term intervention for older people, with an emphasis on rehabilitation to enable a safe return to their own home environment. A government audit report in 2003 concerning effective discharge of older patients from NHS acute hospitals stated that delayed discharges are a significant problem, with 17 per cent caused by delays in assessing patients, shortages of occupational therapists and lack of integrated therapy services. 5 figs. 20 refs. [Abstract]

Greene, Jane, et al.

Timely and effective hospital discharge for older people : a person centred approach.

International Journal of Clinical Leadership 2008; 16 (1): 49-57

During the late 1990s, long term care for older people with complex needs was moving from hospital care to community settings: domiciliary, nursing home or residential home (DHSSPSNI, 1990). Needs assessment for these people was carried out within a framework of care management. From November 2004, Craigavon and Banbridge Community Trust moved the care management assessment process out of hospital, allowing for better informed decision making in respect of long term care options. This article tracks the development of a whole systems approach to hospital discharge for older people with complex needs. Using a person centred approach, multidisciplinary assessment and care planning aimed to offer older people an opportunity for further assessment and, if appropriate, rehabilitation, following hospital discharge. This would allow for meaningful, supported decision making with regard to long term care options. Building on the existing intermediate care service, an enhanced intermediate care pathway was developed to facilitate earlier discharge for patients who previously stayed in hospital to undergo the care management assessment and discharge process. The outcomes have demonstrated high levels of user satisfaction, saved hospital bed days and successful rehabilitation resulting in reduced levels of need and reduced service requirements. There is also evidence that some older people are returning to their own homes following a period of supported discharge, with a subsequent reduction in long term admissions to institutional care. The strategic direction towards primary care led health and social services in Northern Ireland has fostered and supported this approach. Following the success of this approach, trusts across the region are now expected to provide complex care assessment and provision for older people in this way. 5 figs. 13 refs. [Abstract]

Baumann, Matt, et al.

Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge.

Health and Social Care in the Community 2007; 15 (4): 295-305 (July 2007)

In recent years, there has been significant concern, and policy activity, in relation to the problem of delayed discharges from hospital. Key elements of policy to tackle delays include new investment, the establishment of the Health and Social Care Change Agent Team, and the implementation of the Community Care (Delayed Discharge) Act 2003. Whilst the problem of delays has been widespread, some authorities have managed to tackle delays successfully. The aim of the qualitative study reported here was to investigate discharge practice and the organisation of services at sites with consistently low rates of delay, in order to identify factors supporting such good performance. Six 'high performing' English sites (each including a hospital trust, a local authority, and a primary care trust) were identified using a statistical model, and 42 interviews were undertaken with health and social services staff involved in discharge arrangements. Additionally, the authors set out to investigate the experiences of patients in the sites to examine whether there was a cost to patient care and outcomes of discharge arrangements in these sites, but unfortunately, it was not possible to secure sufficient patient participation. Whilst acknowledging the lack of patient experience and outcome data, a range of service elements was identified at the sites that contribute to the avoidance of delays, either through supporting efficiency within individual agencies or enabling more efficient joint working. Sites still struggling with delays should benefit from knowledge of this range. The government's reimbursement scheme appears to have been largely helpful in the study sites, prompting efficiency-driven changes to the organisation of services and discharge systems, but further focused research is required to provide clear evidence of its impact nationally, and in particular, how it impacts on staff, and patients and their families. 1 fig. 27 refs. [Abstract]

Garasen, Helge, et al.

Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients : a randomised controlled trial.

BMC Public Health 2007; 7 (68): (2 May 2007)

BACKGROUND: Demographic changes together with an increasing demand among older people for hospital beds and other health services make allocation of resources to the most efficient care level a vital issue. The aim of this trial was to study the efficacy of intermediate care at a community hospital compared to standard prolonged care at a general hospital. METHODS: In a randomised controlled trial 142 patients aged 60 or more admitted to a general hospital due to acute illness or exacerbation of a chronic disease 72 (intervention group) were randomised to intermediate care at a community hospital and 70 (general hospital group) to further general hospital care. RESULTS: In the intervention group 14 patients (19.4 per cent) were readmitted for the same disease compared to 25 patients (35.7 per cent) in the general hospital group (p = 0.03). After 26 weeks 18 (25.0 per cent) patients in the intervention group were independent of community care compared to seven (10.0 per cent) in the general hospital group (p = 0.02). There were an insignificant reduction in the number of deaths and an insignificant increase in the number of days with inward care in the intervention group. The number of patients admitted to long-term nursing homes from the intervention group was insignificantly higher than from the general hospital group. CONCLUSION: Intermediate care at a community hospital significantly decreased the number of readmissions for the same disease to general hospital, and a significantly higher number of patients were independent of community care after 26 weeks of follow-up, without any increase in mortality and number of days in institutions. 2 figs. 4 tables 26 refs. [Abstract]

http://www.biomedcentral.com/content/pdf/1471-2458-7-68.pdf

Moore, Jeanette, et al.

Networks and governance : the case of intermediate care.

Health and Social Care in the Community 2007; 15 (2): 155-164 (March 2007)

The present paper describes a novel approach to the study of services conceptualised as networks. It uses data collected as part of a case study evaluation of intermediate care, a 'joined-up government' policy that was explicitly intended to dissolve the boundaries between health and social care services. The evaluation was undertaken in five localities in England. Routine service use data were collated and standardised for the twelve-month period from November 2002 to October 2003. A cohort of 258 service users was recruited during a census month (June 2003), and more detailed data on their personal characteristics and experiences prior to and during their intermediate care episode were collected. Information was obtained for 153 of these people, covering their experience during the six months following discharge. A graphical method of depicting individuals' movements between services was devised and a number of measures were used to investigate the network-like features of the data. User outcomes were explored by examining the relationship of characteristics of service users to their location at six months after discharge. The results of the analyses show that the five sites were developing service configurations that facilitated transitions between health, social care and other services, and that individual needs were taken into account in the decisions made about which people transferred into which services. While the results cannot be said to show that joined-up government works, they are consistent with the argument that joined-up government goes beyond partnership-type concepts, and in practice, involves the creation of what might be termed integrated service networks. 1 fig. 6 tables 39 refs. [Abstract]

Scourfield, Peter

Issues arising for older people at the 'interface' of intermediate care and social care.

Research Policy and Planning 2007; 25 (1): 57-67

In recent years both the Health Act 1999 and the Health and Social Care Act 2001 have paved the way for integrated care trusts with the aim of bringing about more flexible, person centred services for older people. Concern to avoid both unnecessary hospital admissions and so called 'bed-blocking' has led to the expansion of intermediate care services. The National Service Framework for Older People, published in 2001, further articulated these ambitions. Evaluations to date have indicated that, whilst further research is still needed to see whether all the goals have been effectively realised, intermediate care is associated with a range of perceived benefits. However, this paper highlights the fact that, on the ground, there remain certain unresolved difficulties at the point where intermediate care ends and where social care begins that need further consultation before it can be said that services are properly 'joined up' and 'person centred'. Implications for both practice and policy are considered. 28 refs. [Abstract]

Doyle, Dave and Cornes, Michelle

Mainstreaming interprofessional partnerships in a metropolitan borough.

Journal of Integrated Care 2006; 14 (5): 27-36 (October 2006)

This article draws on 'practice wisdom' to reflect on the development of interprofessional partnerships for older people in a metropolitan borough in the North West of England. We suggest that most interprofessional partnership working continues to set outside mainstream services, and that integration and seamless service remain a significant challenge. We focus on local plans for service reconfiguration ('Go Integral') and their likely implications for non-traditional services such as intermediate care and falls prevention. Finally, we show how social care and social work values can be used to glue the system together so that it becomes easily accessible and meaningful to older people. 2 figs. 27 refs. [Abstract]

Metcalfe, J.

Enhancing the care of older people in the community.

Nursing Standard 2006; 21 (7): 35-39 (25 October 2006)

This article describes a pilot project that aimed to enhance the care of older people who dialled 999 but did not require hospital admission. The project demonstrated how intermediate care teams and the ambulance service worked in partnership to avoid unnecessary hospital admission and to improve health and social care services for this patient group. 1 table 5 refs. [Summary]

Wilson, A., et al.

Development and testing of a questionnaire to measure patient satisfaction with intermediate care?

Quality & Safety in Health Care 2006; 15 (5): 341-319 (October 2006)

BACKGROUND: Individual trials have suggested high levels of general patient satisfaction with intermediate care, but this topic has not been examined in detail. AIMS: To identify the key elements of patient satisfaction with intermediate care, and to see whether these can be validly measured using a questionnaire. METHOD: A questionnaire was developed on the basis of a literature review and piloting with patients and staff on participating schemes (phase I). In phase II, the questionnaire was tested for validity and reliability in a group of patients recently discharged from two "hospital-at-home" intermediate-care schemes. In phase III, a shortened version of the questionnaire was psychometrically tested in five sites taking part in a national evaluation of intermediate care. RESULTS: Ninety-six patients with an average age of 76.5 years took part in phase II. Test-retest reliability was evaluated by repeating the questionnaire two weeks later in a subsample of 42 patients. This was "moderate" (0.4-0.6) for twelve questions, "fair" (0.2-0.4) for six questions and "poor" (0.1-0.2) for five questions. Scores correlated well with the Client Satisfaction Questionnaire (Spearman's r = 0.75, $p<0.001$). 843 patients (57 per cent of those eligible) from five intermediate-care schemes took part in phase III. Principal components analysis suggested six factors or subscales: general satisfaction, affective response, cognitive response, timing of discharge, coordination after discharge, and access to pain relief, although the last three factors comprised only one question each. The intraclass correlation coefficients in the first three subscales varied from 0.82 to 0.89. Scores for all subscales differed by scheme, suggesting construct validity. Only one question (on general satisfaction) was found to be redundant. CONCLUSION: The questionnaire, with some minor amendments to improve performance, could be used as a validated tool for audit and research in intermediate care. An amended version and scoring programme is available from us on request. 5 tables 23 refs. [Abstract]

Mayhew, Leslie and Lawrence, David

The costs and service implications of substituting intermediate care for acute hospital care.

Health Services Management Research 2006; 19 (2): 80-93 (May 2006)

Intermediate care is part of a package of initiatives introduced by the UK Government mainly to relieve pressure on acute hospital beds and reduce delayed discharge (bed blocking). Intermediate care involves caring for patients in a range of settings, such as in the home or community or in nursing and residential homes. This paper considers the scope of intermediate care and its role in relation to acute hospital services. In particular, it develops a framework that can be used to inform decisions about the most cost-effective care pathways for given clinical situations, and also for wider planning purposes. It does this by providing a model for evaluating the costs of intermediate care services provided by different agencies and techniques for calibrating the model locally. It finds that consistent application of the techniques over a period of time, coupled with sound planning and accounting, should result in savings to the health economy. 4 tables 14 refs + 1 appendix [Abstract]

Ellis, Annie, et al.

Buying time II : an economic evaluation of a joint NHS/social services residential rehabilitation unit for older people on discharge from hospital.

Health and Social Care in the Community 2006; 14 (2): 95-106 (March 2006)

The study's aim was to investigate the cost-effectiveness of an NHS/social services short-term residential rehabilitation unit (a form of intermediate care) for older people on discharge from community hospital compared with 'usual' community services. An economic evaluation was conducted alongside a prospective controlled trial, which explored the effectiveness of a rehabilitation unit in a practice setting. The aim of the unit was to help individuals regain independence. A matched control group went home from hospital with the health/social care services they would ordinarily receive. The research was conducted in two matched geographical areas in Devon: one with a rehabilitation unit, one without. Participants were recruited from January 1999 to October 2000 in ten community hospitals and their eligibility determined using the unit's strict inclusion/exclusion criteria, including 55 years or older and likely to benefit from a short-term rehabilitation programme: potential to improve, realistic, achievable goals, motivation to participate. Ninety-four people were recruited to the intervention and 112 to the control group. Details were collated of the NHS and social services resources participants used over a twelve-month follow-up. The cost of the resource use was compared between those who went to the unit and those who went straight home. Overall, costs were very similar between the two groups. Aggregated mean NHS/social services costs for the twelve months of follow-up were £8,542.28 for the intervention group and £8,510.68 for the control. However, there was a clear 'seesaw' effect between the NHS and social services: the cost of the unit option fell more heavily on social services (£5,011.56, whereas £3,530.72 to the NHS), the community option more so on the NHS (£5,146.74, whereas £3,363.94 to social services). This suggests that residential rehabilitation for older people is no more cost-effective over a year after discharge from community hospital than usual community services. The variability in cost burden between the NHS and social services has implications for 'who pays' and being sure that agencies share both pain and gain. 6 tables 16 refs. [Abstract]

Trappes-Lomax, Tessa, et al.

Buying time I : a prospective, controlled trial of a joint health/social care residential rehabilitation unit for older people on discharge from hospital.

Health and Social Care in the Community 2006; 14 (1): 49-62 (January 2006)

The study's objective was to determine the effectiveness of a joint NHS/Social Services rehabilitation unit (a form of intermediate care) for older people on discharge from community hospital, compared with 'usual' community services. This was a controlled clinical trial in a practice setting. The intervention was six weeks in a rehabilitation unit where individuals worked with care/rehabilitation assistants and occupational therapists to regain independence. Controls went home with the health/social care services they would ordinarily receive. Participants were from two matched geographical areas in Devon: one with a rehabilitation unit, one without. Recruitment was from January 1999 to October 2001 in ten community hospitals. Study eligibility was assessed using the unit's inclusion/exclusion criteria: 55 years or older and 'likely to benefit from a short-term rehabilitation programme' ('potential to improve', 'realistic and achievable goals' and 'motivation to participate'). Ninety-four people were recruited to the intervention and 112 to the control. The mean (standard deviation) age was 81.8 (8.0) years. The main outcome measure was prevention of institutionalisation assessed by the number of days from baseline interview to admission to residential/nursing care or death ('survival-at-home time'). Secondary outcome measures were time to hospital re-admission over twelve months, quality of life and coping ability. There were no significant differences between the groups on any outcome measure. Adjusted hazard ratio (95 per cent CI) for 'survival-at-home time' was 1.13 (0.70-1.84), and 0.84 (0.53-1.33) for 'time to hospital re-admission'. However, attending the unit was associated with earlier hospital discharge. Median (interquartile range) days in hospital for the intervention graph was 27 (20, 40), and for the control graph was 35 (22, 47) (U = 4,234, P = 0.029). These findings suggest a stay in a rehabilitation unit is no more effective than 'usual' care at diverting older people from hospital/long-term care. Alternative service configurations may be as effective, having implications for tailoring services more specifically to individual need and/or user preferences. However, the unit did appear to facilitate earlier discharges from community hospital. 4 figs. 3 tables 32 refs. [Abstract]

Cornes, Michelle and Manthorpe, Jill

Someone to expect each day.

Community Care 2005; (1602): 36-37 (8 December 2005)

Intermediate care is often seen as a lifeline to establishing older people's independence after hospital. But limiting it to six weeks is wrong, says Michelle Cornes and Jill Manthorpe. 4 refs. [Abstract]

http://www.communitycare.co.uk/Articles/08/12/2005/52055/Someone-to-expect-each-day.htm

Wilmot, Claire

Intermediate care : connecting housing and health.

Working with Older People 2005; 9 (4): 16-19 (December 2005)

Intermediate care is a set of services which cross existing boundaries, providing care for people who no longer require accommodation and support in hospital, yet are still in need of temporary care to get back to normal living. Here, Claire Wilmot explains about Hanover's 'Up&About' intermediate care service, its facilities and the secret behind its success. 3 refs. [Introduction]

Ward, S., et al.

Evaluating a respiratory intermediate care team.

Nursing Standard 2005; 20 (5): 46-50 (12 October 2005)

This article examines the work of a respiratory intermediate care team. Findings from an audit and a patient satisfaction postal questionnaire are presented to assess the effectiveness of the team's work and evaluate the effect of specialist nursing teams on hospital bed days and patient preference. From the evaluation it is apparent that the respiratory intermediate care team is an effective means of saving hospital bed days through prevention of admission and early discharge in patients with chronic respiratory disease. 5 figs. 13 refs. [Summary]

Mackenzie, Mathew, et al.

Profiling intermediate care patients using the single assessment process : a road to better service provision?

Journal of Integrated Care 2005; 13 (4): 43-48 (August 2005)

This paper demonstrates that three intermediate care services in Shepway, East Kent each cater for distinct patient groups, and that data from a single assessment process (S.A.P.) tool can be used to differentiate between them. By applying statistical techniques, inferences can be made about the likelihood of admission to a particular service, given specific health characteristics. In conclusion, we highlight the utility of standardised assessment as a means of providing data for audit and planning, and stress the importance of the S.A.P. as a means of developing care services. 3 figs. 1 table 14 refs. [Abstract]

Young, John, et al.

A prospective baseline study of frail older people before the introduction of an intermediate care service.

Health and Social Care in the Community 2005; 13 (4): 307-312 (July 2005)

This paper describes the first part of a two-stage research project designed to investigate the clinical and service outcomes of a comprehensive intermediate care service. It is a baseline study of patients presenting to two elderly care departments as emergencies with the clinical syndromes of falls, incontinence, confusion or poor mobility before the introduction of a city-wide intermediate care service. The outcome measures were: mortality; disability (Barthel Index, BI); social activities (Nottingham Extended Activities of Daily Living); service use; and carer distress (General Health Questionnaire -28). These were measured at three, six and twelve months after recruitment. Eight hundred and twenty-three patients were recruited (median age = 84 years; proportion of women = 70 per cent; proportion with cognitive impairment = 45 per cent; median BI score = 15). There was a high mortality rate (36 per cent), evidence for incomplete recovery, a gradual decline in independence over twelve months and a high degree of carer stress. There was little use of rehabilitation services (< five percent), about 25 per cent required readmission to hospital by each assessment point and there was a gradual increase in institutional care admissions. These findings support a needs-based argument for a more comprehensive community service for frail older people. 2 tables 25 refs. [Abstract]

Plochg, Thomas, et al.

Intermediate care : for better or worse? : process evaluation of an intermediate care model between a university hospital and a residential home.

BMC Health Services Research 2005; 5 (38): (May 2005)

BACKGROUND: Intermediate care was developed in order to bridge acute, primary and social care, primarily for elderly persons with complex care needs. Such bridging initiatives are intended to reduce hospital stays and improve continuity of care. Although many models assume positive effects, it is often ambiguous what the benefits are and whether they can be transferred to other settings. This is due to the heterogeneity of intermediate care models and the variety of collaborating partners that set up such models. Quantitative evaluation captures only a limited series of generic structure, process and outcome parameters. More detailed information is needed to assess the dynamics of intermediate care delivery, and to find ways to improve the quality of care. Against this background, the functioning of a low intensity early discharge model of intermediate care set up in a residential home for patients released from an Amsterdam university hospital has been evaluated. The aim of this study was to produce knowledge for management to improve quality of care, and to provide more generalisable insights into the accumulated impact of such a model. METHODS: A process evaluation was carried out using quantitative and qualitative methods. Registration forms and patient questionnaires were used to quantify the patient population in the model. Statistical analysis encompassed T-tests and chi-squared test to assess significance. Semi-structured interviews were conducted with 21 staff members representing all disciplines working with the model. Interviews were transcribed and analysed using both 'open' and 'framework' approaches. RESULTS: Despite high expectations, there were significant problems. A heterogeneous patient population, a relatively unqualified staff and cultural differences between both collaborating partners impeded implementation and had an impact on the functioning of the model. CONCLUSION: We concluded that setting up a low intensity early discharge model of intermediate care between a university hospital and a residential home is less straightforward than was originally perceived by management, and that quality of care needs careful monitoring to ensure the change is for the better. 2 figs 4 tables 46 refs. [Abstract]

http://www.biomedcentral.com/content/pdf/1472-6963-5-38.pdf

Auty, Simon

Intermediate care : how to reduce hospital admissions.

BMJ Careers : Career Focus 2005; 331 (7481): 3-4 (2 July 2005)

Simon Auty explains how general practitioners with a special interest in intermediate care can play a key role in keeping elderly people out of hospital. 2 refs. [Introduction]

http://careers.bmj.com/careers/advice/view-article.html?id=963

Walsh, Bronagh, et al.

Economic evaluation of nurse led intermediate care versus standard acute care for post-acute medical patients : cost minimisation analysis of data from a randomised controlled trial.

BMJ 2005; 330 (7493) 699-702 (26 March 2005)

OBJECTIVE: To undertake an economic evaluation of nurse led intermediate care compared with standard hospital care for post-acute medical patients. DESIGN: Cost minimisation analysis from an NHS perspective, comprising secondary care, primary care, and community care, using data from a pragmatic randomised controlled trial. SETTING: Nurse led unit and acute general medical wards in large, urban, UK teaching hospital. PARTICIPANTS: Two hundred and thirty-eight patients. OUTCOME MEASURE: Costs to acute hospital trusts and to the NHS over six months. RESULTS: On an intention to treat basis, nurse led care was associated with higher costs during the initial admission period (nurse led care £7,892 ($14, 970; 11,503), standard care £4,810, difference £3,082 (95 per cent confidence interval £1,161 to £5,002)). During the readmission period, costs were similar (nurse led care £1,444, standard care £1,879, difference -£435, -£1,406 to £536). Total costs at six months were significantly higher (nurse led care £10,529, standard care £7,819, difference £2,710, £518 to £4,903). Sensitivity analyses suggested that the trend for nurse led care to be more expensive was maintained even with substantial cost reductions, although differences were no longer significant. CONCLUSION: Acute hospitals may not be cost effective settings for nurse led intermediate care. Both inpatient and total costs were significantly higher for nurse led care than for standard care of post-acute medical patients, suggesting that this model of care should not be pursued unless clinical or organisational benefits justify the increased investment. [Abstract]

http://bmj.bmjjournals.com/cgi/reprint/330/7493/699

WEB RESOURCES

Intermediate Care - Joint Improvement Team [Scotland]
http://www.jitscotland.org.uk/action-areas/intermediate-care/

National Audit of Intermediate Care
NHS Benchmarking
http://www.nhsbenchmarking.nhs.uk/icsurvey.aspx

Reablement
Social Care Institute for Excellence
http://www.scie.org.uk/topic/careservices/preventionreablement/reablement

Reading lists

Reading lists are available at:
www.kingsfund.org.uk/readinglists ; email library@kingsfund.org.uk ; telephone 020 7307 2568

Age discrimination

Black & minority ethnic older people

Clinical governance

Clinical leadership

Electronic patient records

Encouraging healthy behaviour

End of life care

Enhancing the healing environment

Ethnic health - an introduction to ethnic health issues

Ethnic health issues for primary care

Financial pressure in the NHS

Future demands on health & social care

Future of social care funding

Health inequalities

Improving care for long term conditions

Inpatient mental health services

Integrated care and partnership working

Intermediate care

International health care comparisons

Leadership in the NHS

London - an introduction to London health issues

Maternity services

Mental health – black & minority ethnic communities

Mental health services for young people

NHS reforms

NHS workforce

Older people and mental health

Patient choice of provider

Payment by results

Point of care : improving patients' experience

Practice based commissioning

Public health in England

Public involvement in health services

Refugee health care

Technology in health & social care : telehealth, telecare and telemedicine

Workforce diversity in health & social care