

**A National Evaluation of Intermediate Care (1)
challenges, benefits and weaknesses:
qualitative study**

Emma Regen, Graham Martin, Jon Glasby, Graham Hewitt, Susan Nancarrow, Hilda Parker

Corresponding author:

Emma Regen MA, Research Fellow, Leicester Nuffield Research Unit (formerly Nuffield Community Care Studies Unit), Department of Health Sciences, University of Leicester, 22-28 Princess Road West, Leicester, LE1 6TP

Email: elr14@leicester.ac.uk

Tel:

Fax:

Graham Martin MSc, Research Fellow, formerly Research Associate, Nuffield Community Care Studies Unit, University of Leicester, now IGBiS, University of Nottingham

Jon Glasby PhD, Senior Lecturer, Health Services Management Centre, University of Birmingham

Graham Hewitt BA (Hons), PGDip, Research Governance Manager, formerly Research Associate, Nuffield Community Care Studies Unit, University of Leicester, now Leicestershire, Northamptonshire and Rutland Primary Care Research Alliance

Susan Nancarrow PhD, Primary Care Research Coordinator, Trent RDSU, The University of Sheffield

Hilda Parker BA (Hons), CQSW, Senior Research Fellow, formerly Research Fellow, Nuffield Community Care Studies Unit, University of Leicester, now Division of Primary Care, University of Nottingham

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Introduction

First articulated as a formal policy in the NHS Plan (Department of Health 2000a) and forming a key component of the National Service Framework for Older People (Department of Health 2001a) the implementation of intermediate care has been a policy imperative for all those involved in the commissioning and provision of care for older people since 2000. In promoting the development of a new range of intermediate care services to ‘bridge the gap’ between hospital and primary and community care (Department of Health 2000a) the government was largely responding to problems with the free flow of patients through and out of acute hospital care as highlighted by the Audit Commission (Audit Commission 1997) and the National Beds Inquiry (Department of Health 2000b). Accordingly, while the precise nature and definition of intermediate care has remained a matter for considerable debate (Steiner 2001, Melis *et al.* 2004) in general terms it can be said to comprise services, primarily catering for older people, which seek to prevent unnecessary hospital admissions, facilitate earlier discharges and avoid premature admissions to long-term care (Department of Health 2001b). Implementation has been underpinned by several policy statements which have set out targets relating to intermediate care (Department of Health 2000a) as well as a working definition (box 1).

Box 1: The definition of intermediate care

According to Health Service Circular 2001/001 (Department of Health 2001b)

intermediate care services should meet all of the following criteria:

- They are targeted at people who would otherwise face unnecessary prolonged hospital stays, or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care
- They 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
- They have a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- They are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Intermediate care is not a new idea. A range of schemes has proliferated since the early 1990s and some evidence for the effectiveness of particular interventions has been available for a while (Wilson *et al.* 1999, Parker *et al.* 2000, Steiner *et al.* 2001, Young 2002). The government's decision to pursue a formal policy of intermediate care and roll-out services nationally, however, drew criticism from a range of quarters. Some spoke in terms of 'discriminatory ageism', expressing concerns that older people could be inappropriately diverted away from medical services in a bid to alleviate pressures in acute care (British Geriatric Society & Age Concern 2002, Ebrahim 2001, MacMahon 2001). Others highlighted what they regarded as a paucity of evidence to support the widespread development of intermediate care (Grimley

Evans & Tallis 2001, Pencheon 2002). In this context the Department of Health (Policy Research Programme) commissioned a £1.2 million programme of evaluation of intermediate care, funding three major studies which have recently reported their findings.

The data reported in this and the following paper are based upon the case-study component of a multi-method national evaluation of the costs and outcomes of intermediate care for older people conducted by a team from the Universities of Leicester and Birmingham. This first paper presents the findings of qualitative research which examined the views of practitioners and managers on the challenges, benefits and weaknesses associated with the implementation of intermediate care. The second paper draws upon quantitative data in order to provide an economic analysis of the costs and health outcomes of intermediate care.

Subjects and Methods

Case-study approach

Qualitative and quantitative data collection was conducted in five case-study sites in England between January 2003 and November 2004. The processes used for the collection and analysis of quantitative data in the case-study sites are described in the following paper.

Five primary care trusts were selected as case-studies to represent 'whole systems' (an area with a specific geographical boundary) of intermediate care. By studying whole systems as opposed to individual service models we aimed to achieve a more detailed understanding of the implementation of intermediate care and its impact upon system-

level costs and outcomes. We selected the case-study primary care trusts according to the following criteria:

- a range of intermediate care service operational for at least two-three years
- reasonable throughput into the intermediate care system (at least 1000 cases per annum)
- a mix of urban and rural sites
- senior management support for the collection of routine data by the services themselves
- clinical and managerial support for participation in the evaluation

Data collection

We conducted semi-structured interviews with 36 individuals involved in the strategic development of intermediate care across the five case-study sites. These interviewees were recruited with the help of intermediate care co-ordinators and typically included senior managers and clinicians within primary care trusts, social services and the acute sector. In addition, 25 interviews were conducted with intermediate care service managers and 21 focus groups were held with staff directly involved in the provision of services. Focus groups generally comprised four to eight participants and usually included therapists, nurses, social workers and support workers.

In common with other applied qualitative policy research we developed a topic guide with reference to our research questions and the wider literature (Pope *et al.* 2000).

As well as describing their own roles and the nature/organisation of service provision, participants were invited to reflect upon factors which had shaped the development of intermediate care and to provide an assessment of its strengths and weaknesses.

During the interviews, which typically lasted 60-90 minutes, participants were also able to raise other issues of importance to them.

Data analysis

All interviews and focus-group discussions were recorded and transcribed.

Qualitative data analysis was informed by the ‘framework’ approach which was developed specifically for policy relevant research (Ritchie & Spencer 1994). Data from each case-study site were analysed separately. First, we developed a substantive framework which provided a detailed index of the data typically comprising 30-35 categories. The framework was then applied to the data via the annotation of interview transcripts. Data were subsequently rearranged (via cutting and pasting) into the appropriate part of the substantive framework to which they related. Finally, analytic themes and concepts were developed for each of the categories via a process of mapping and interpretation (Ritchie & Spencer 1994).

Analysis was performed by small teams of researchers who met regularly to discuss and validate the analytic themes and concepts generated from the data. Disconfirming cases were included and themes were modified to take account of these. The quotations included in the results section below serve to illustrate the key emergent themes (codes A-E indicate case-study sites; numbers indicate individuals).

Results

Developing intermediate care – challenges

Difficulties relating to the recruitment and retention of both qualified and non-qualified staff were identified as the most significant challenges to the implementation of intermediate care in all case-study sites. Insufficient funding and problems

attracting staff to posts were highlighted as the main causes. The potential for professional isolation within small community-based teams and a lack of awareness of intermediate care were identified as deterrents by professional staff. For support staff, low wages and long, unsociable hours were perceived as particular barriers to recruitment.

“One of the biggest things that has been the problem is the fact that there has been a lack of a capacity and by that I mean we have not got the staff levels to offer the service we would want to. It is very difficult to get hold of rehab assistants... through one thing and another, be it low money or bad shifts, people don't necessarily want to do that” (E1).

In addition to perceived funding shortages (exacerbated by the absence of ring-fencing), the short-term, non-recurrent nature of some funding for intermediate care was also seen as problematic. Interviewees reported that it was difficult to contemplate service development in the medium to long-term with many staff appointed on short-term contracts and uncertainty over future additional funding. Moreover, wider financial pressures in health and social care systems meant that the primary/community services required to underpin intermediate care were also frequently under-funded.

“The referrals are increasing in the community to keep people at home but the resources haven't increased in keeping with them, there isn't the money, there isn't the home care, there aren't the therapists. We're just running all the time, running” (D4).

A lack of effective joint working between health and social care agencies was highlighted as a major impediment to the implementation of intermediate care in all case-study sites. At the strategic level, competing organisational visions for intermediate care and the existence of separate (as opposed to joint or pooled) budgets had militated against a coherent, ‘whole systems’ approach to service development (Department of Health 2002).

“There has been very good collaborative work between agencies for a number of years... but one of the stopping points, if you like, or the barriers to taking that work forward is different financial budgets for example. Everybody is all for joint working and collaboration until you start asking people to give over... money and that is a constant tension and I think perhaps has stood in the way of really making good progress and having a more flexible model” (A15).

At the operational level, different employment and health and safety policies held by health and social care agencies combined with incompatible information technology and data collection systems to present significant challenges to ‘frontline’ staff.

A perceived lack of support and involvement on the part of the medical profession was identified as a barrier to the development and use of intermediate care services by non-medical interviewees in three case-study sites. Doubts about intermediate care were attributed to concerns about the lack of evidence for its effectiveness and fears that the aim of keeping older people out of hospital was potentially discriminatory.

“The more senior members ... of the medical profession could remember days when older people had been warehoused so to speak in environments outside of hospital because they were not considered worthy of hospital admission and they didn’t want to go back to those days where people were being basically cared for and denied proper assessment and treatment” (B1).

At the same time, however, interviewees in four of the five case-study sites revealed that acute sector clinicians had felt excluded from the development and provision of intermediate care to some degree. Reluctance on the part of some general practitioners (GPs) to provide medical cover for intermediate care facilities was explained in terms of heavy workloads and a lack of incentives.

Benefits of intermediate care

There was a strong perception amongst interviewees in all case-study sites that the main strength of intermediate care was the range of benefits it offered to service users. These were described both in terms of experience and outcomes, particularly when compared with more ‘traditional’ forms of care. In contrast to care provided on a hospital ward, intermediate care was regarded as being responsive, patient-centred, flexible and holistic.

“They get like a one-to-one service. If they’re in a hospital base you get your healthcare assistants with however many other patients there are in a ward. They get individual attention whether it’s from us, whether it’s from their own district nurse in their own home and they thrive on it” (A24).

Interviewees placed significant emphasis upon the ‘homely environment’ in which intermediate care services were delivered. Be it home or a residential environment, the intermediate care setting was generally regarded as being beneficial, particularly in achieving outcomes such as independence and increased confidence. Again, these benefits were described in the context of the dependency that was perceived to follow a stay in hospital.

By delivering services in an individual’s own home, the ‘upheaval’ and potential for confusion in response to unfamiliar hospital surroundings could be avoided.

Moreover, service users could retain much valued support networks and social activities seen as essential to their rehabilitation. In addition, some interviewees suggested that as a result of ‘being on their own territory’, users and their relatives played a more active role in rehabilitation planning and goal setting.

The establishment of effective multi-disciplinary team-working was reported as a strength of many of the intermediate care services and was regarded as having benefits for staff as well as users. Interviewees spoke positively of the support they received from fellow team members and of being able to access expertise from a range of professionals. While recognising their limitations, many practitioners welcomed increased opportunities for role flexibility in the intermediate care setting as they undertook tasks which would normally be performed by others.

“As I said before we’re multi-disciplinary but we’re also very inter-disciplinary. But having said that we know our boundaries so as a nurse going out to see a patient I would carry out my nursing tasks but I wouldn’t just go out there and do my nursing

tasks, which would happen on a ward. There wouldn't be such an overlap [on a ward] as there is within the team...so if they're having to carry out an exercise programme then it would be expected of me as a nurse to go through that exercise programme with them on behalf of the physio" (A5).

Staff also spoke of the job satisfaction they had gained from being involved in the delivery of intermediate care. This appeared to be inextricably linked with the goal of restoring or maintaining the independence of service users.

Weaknesses of intermediate care

There was a view in all case-study sites that intermediate care services did not have the capacity to fulfil their potential for alleviating pressures within health and social care systems. Interviewees drew attention to limitations in terms of numbers of beds and places, staffing levels and operating hours. These problems were frequently attributed to insufficient funding for intermediate care and recruitment difficulties.

"It would be lovely to have a big enough service that you could immediately respond to everybody but .. in such a financially restricted situation, as we find ourselves in in the NHS [that] is not necessarily available...But we need a lot of extra resources to actually make the service as reactive and as supportive as in many ways it needs to be" (A7).

A particular problem in three of the case-study sites was a shortage of care workers and rehabilitation assistants. This had led to an inability to cater for potential service users even when all criteria were met and therapist input was available. In addition,

lack of mainstream home care in these sites sometimes meant that patients who could otherwise receive intermediate care in their own homes could not be left safely overnight or receive assistance with daily activities. Potential service users were sometimes admitted to hospital as a result. The inability of many intermediate care services to respond to referrals or to provide care out-of-hours was identified as a particular problem for GPs who sometimes had no option but to admit patients to hospital.

Lack of knowledge about intermediate care services and difficulties in accessing them presented barriers to their use within all case-study sites. In addition, the eligibility criteria for services were often perceived as too narrow by referrers. As a result, intermediate care was sometimes seen as being rather 'elitist' and accusations of 'cherry-picking' were not uncommon. Recurring problems admitting patients to intermediate care meant that practitioners often reverted to more traditional forms of care.

“So the experience on the ground, when I talk to people in the hospital and say... ‘this looks like intermediate care to me, did you phone last night? You know, we’ve been telling you about it’, he said ‘oh that was no good, I phoned and they weren’t interested’ or ‘they said they didn’t have any space’. ‘I’m losing faith in intermediate care’, ‘I can’t see the point’, I get comments like that all the time” (E5).

A small number of interviewees felt that more could be done to address issues of perceived risk in relation to intermediate care as part of developing confidence in such services.

“The big cultural thing we found in particular about the intermediate care beds is hospital staff being prepared to take the risk and discharge somebody to something new that is relatively untested and unknown...So it is starting to overcome those barriers. Part of it is actually once somebody has put a patient through intermediate care then they have got the confidence to do it again” (D16).

Alongside under-use, the other main tension between intermediate and secondary care services was inappropriate use of intermediate care. Highlighted as an issue in all case-study sites, many interviewees were concerned that intermediate care was becoming dominated by an acute care agenda that focused more upon freeing up beds than it did on working at the pace of the individual older person and finding the right environment to maximise their recovery.

A lack of integration between individual intermediate care services was highlighted as another area of weakness in four case-study sites. This manifested itself in problems relating to access, care pathways and resistance to flexible working, for example, across services. Lack of co-ordination and integration between intermediate care services was regarded as a legacy of the ad-hoc, ‘bottom-up’ way in which many services had evolved. In terms of the range of provision, some interviewees reported that older people with mental health problems were poorly served by existing services due to a lack of specialist mental health input in intermediate care. Others saw the national and local focus upon early supported discharge and beds-based services as misguided and argued for more proactive services in the form of admission avoidance and community-based intermediate care.

Discussion

Our findings reveal workforce and funding shortages, poor joint working and scepticism/disengagement on the part of the medical profession as the main challenges to the development of intermediate care. The main perceived benefits of intermediate care for service users were described in terms of patient-centredness, flexibility and the promotion of independence. Staff highlighted the opportunities associated with working in multi-disciplinary/inter-disciplinary environments as key benefits. Insufficient capacity, problems of access and awareness at the interface between intermediate care and ‘mainstream’ services combined with poor coordination between intermediate care services were identified as the main weaknesses in provision.

Limitations of the study

As our main contacts in the case-study sites, intermediate care co-ordinators were largely responsible for identifying potential interviewees on our behalf. Despite making it clear that we wished to gain access to a range of perspectives, the majority of those selected for interview were generally directly involved in either the management or delivery of intermediate care and hence potentially more favourable in their views. It should be noted, however, that interviewees did not refrain from describing weaknesses regarding the implementation of intermediate care.

The fact that we did not interview service users about their experiences of intermediate care could be seen as another weakness in our approach. It should be pointed out, however, that a patient satisfaction survey was conducted for all intermediate care services across the five case-study sites. This revealed relatively

high levels of satisfaction with intermediate care and as such lends support to the perceptions of practitioners and managers who identified significant benefits for users (Wilson *et al.* 2006).

Relevance to the existing literature

Our study of whole systems of intermediate care supports many of the findings reported in evaluations of particular intermediate care schemes. The perceived benefits for patients, usually linked to the ‘homely’ care environment, have been described previously (Wilson *et al.* 2002, Roe *et al.* 2003, Martin *et al.* 2005).

Likewise, disengagement, lack of awareness and doubts about intermediate care on the part of GPs and hospital doctors have also been highlighted (MacMahon 2001, Wilson & Parker 2003). A prominent finding from our work was the extent to which workforce shortages and insufficient capacity within intermediate care were perceived to have hindered its development. Again, this has been highlighted in previous research (Nancarrow 2005). Our findings support and reinforce the view that intermediate care needs to form part of a continuum of services linking primary, community, secondary and social care provision if it is to achieve its potential (Department of Health 2002, Asthana & Halliday 2003).

Implications for policy and practice

Workforce and capacity shortages have reportedly limited the ability of intermediate care services to respond to and accept referrals. Given that interviewees described both capacity pressures and a lack of referrals from mainstream services, it would appear that capacity needs to be expanded significantly if intermediate care is to deliver its objectives and meet potential demand. That being so, the ability to secure access to long-term funding and to attract both qualified and non-qualified staff to

intermediate care would appear to be important priorities at the local level. Concerns about capacity, however, need to be understood in the context of the quantitative data presented in the following paper. Findings presented here suggest that a significant proportion of intermediate care referrals represent an additional, rather than a substitute service.

Fragmentation and poor integration with other services have reportedly compromised the extent to which intermediate care can alleviate pressure within health and social care systems. We identified improved joint working between health and social services, better co-ordination between intermediate care services and increased integration between intermediate, primary and secondary care as the key areas for development in fostering the whole systems approach advocated in government policy (Department of Health 2002, Asthana & Halliday 2003).

The need to promote awareness about and confidence in intermediate care amongst doctors and other potential referrers is another priority. The collection and dissemination of robust evidence regarding the effectiveness of intermediate care is crucial to this process. There would appear to be considerable scope for GPs to be more directly involved in the delivery of intermediate care services, particularly those aimed at preventing unnecessary hospital admissions. It is recognised that such involvement would be contingent upon appropriate incentives and support being made available (Wilson & Parker 2003).

Finally, our research has implications in terms of the future direction of intermediate care policy and practice. We identified calls for a shift in emphasis away from beds

towards non-residential forms of intermediate care and admission avoidance schemes. This appeared to reflect a desire for services to become more proactive in the interests of effectiveness and efficiency. Again, these views need to be considered alongside findings reported in the following paper which examines the costs and outcomes associated with particular types of intermediate care.

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Ethical approval

Ethical approval was granted by the Trent Multicentre Research Ethics Committee.

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