# Involving individual older patients and their carers in the discharge process from acute to community care: implications for intermediate care

## Key messages

- Guidance and standards outlined by the Department of Health call for more patient-centred care for older people, including their individual involvement in decisions relating to their own care.

- Patient and public involvement in the provision of health and social services is a key element of government policy, but older people are not usually consulted about the planning of their discharge or care.

- There is almost no research on individual patient or carer involvement in intermediate care, either on assessment and discharge to intermediate care, or on the care itself. However, research does address the involvement of individual older users in the provision of more general health and social services.

- Some older people voluntarily express opinions about their discharge and care, while many others are happy to do so when prompted. However, some older people can be reluctant to express any views, and others do not want to play any role at all in the decision-making process.

- Communication is recognised to be an essential part of user involvement, but older patients who wish to be involved in decisions regarding their care may be prevented from doing so by cognitive impairments, frailty, very poor health, language difficulties, or a lack of confidence when faced with health and social care staff.

- Carers of older people experience the same lack of involvement in discharge planning as the patients. The system often fails to consult with them about their own needs and concerns.

## Introduction

This section introduces and defines the scope of the briefing and the topic.

A SCIE briefing provides up-to-date information on a particular topic. It is a concise document summarising the knowledge base in a particular area and is intended as a 'launch pad' or signpost to more in-depth investigation or enquiry. It is not a definitive statement of all evidence on a particular issue. The briefing is divided into the different types of knowledge relevant to health and social care research and practice, as defined by the Social Care Institute for Excellence (SCIE) (1). It is intended to help health and social care practitioners and policy-makers in their decision-making and practice.

The topic of this briefing is the involvement of individual patients and carers in the process of assessment and discharge to community care, especially intermediate care. Intermediate care essentially acts as a bridge between social, primary and secondary care services (2,3). It aims "to provide an integrated service to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximize independent living" (4). It is "a short term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The care is person-centred, focused on rehabilitation and delivered by a combination of professional groups" (5). It is not expected to last more than six weeks (6). The nature of intermediate care can be extremely broad-ranging and extensive, however. It may encompass everything from step-up and step-down beds or care, to low-level social rehabilitation (7-10). The majority of this care is provided by a combination of health and social care professionals, and therefore requires an integrated and collaborative approach from these services (7,8,11). The client group considered by this briefing is older people only (aged 65 and over).

This briefing does not consider the general strengths or weaknesses of current or proposed intermediate care programmes, or the effectiveness or cost-effectiveness of this type of care as a service. Nor does it consider the benefits or limitations of intermediate care as a concept, the roles of the various professionals involved in providing this care, or the appropriateness of criteria for discharge or admission. This is all discussed in great depth elsewhere (8,12-20). This briefing is concerned with the participation of individual patients and carers, rather than groups, in the planning of discharge to intermediate care. For the purpose of this briefing, user participation or involvement is defined as health and social care professionals seeking the views of individual older patients and their carers about their discharge and care. The briefing therefore aims to examine the findings of the research and policy literature into the means, benefits and difficulties of involving patients in the planning of discharge to community or intermediate care. It will also consider the role of carers in this process, as well as what happens when an older person's ability to communicate their preferences in these matters is affected by dementia, language difficulties, or an unwillingness or reluctance to express preferences about the provision of care. There is limited research

on the involvement of individual older patients and carers on discharge to intermediate care itself. This briefing therefore also examines policy and research findings on older people's involvement in discharge planning more generally. This obviously has implications for the participation or involvement of older users in discharge planning to intermediate care.

## Why this issue is important

This section summarises research findings relating to older patients' involvement in their care, as well as the key characteristics of this group.

The delivery of intermediate care is a key element of government policy (21). It is anticipated that there will be a 300 percent increase in numbers of the very old (aged 85 and over) in the next 50 years, and a substantial increase in older people aged 65-84 in the next 30 years (22). According to the National Service Framework, up to 20 percent of hospital beds are being occupied by older people as a result of inappropriate or unnecessary admissions, or failure to discharge (23). A report by the National Audit Office found that almost 9 percent of patients over 75 who have been declared fit to leave hospital remain in acute care (24), and two other reports have suggested that older people may be being forced into long term care when intermediate care may be more appropriate (3,25). Intermediate care and discharge planning are therefore an increasingly important area of interface between health and social care (26,27). This is also partly because social services must reimburse health services when they are unable to provide social care to people who are ready to be discharged from acute care, as outlined by the 2003 Community Care [Delayed Discharges, etc.] Act (26). Although there is a whole range of local and institutional reasons for delayed discharge (26,27), the failure to assess a patient's care needs, or to arrange the necessary intermediate care, are common reasons for delaying the discharge of older people (24).

The need to involve individual older patients and their carers in discharge planning is important because guidance and standards defined by the Department of Health call for more patient-centred care for older people (4,23). Guidance on the discharge and care of stroke patients also advocates patient and carer consultation (28). The aim is to "ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social care boundaries" (23). Staff working in community and intermediate care, especially assessment and discharge, consider it important to involve older people and their carers in decisions about the planning of their care (15,29,30), and research from both the UK and the United States has demonstrated that involving individual patients in the planning of their care can improve services and outcomes in terms of readmissions and patient satisfaction (7,30-39). Department of Health documents also state that patient involvement promotes "more responsive services and better outcomes of care" (40). The involvement of individual carers has also been found to improve their satisfaction with services and acceptance of their caring role

(41). Concerning carers, government policy also states that "at the time of discharge, carers must feel fully informed and involved in the planning of future care of the patient, so that assumptions are not made about their ability of willingness to care" (42). It is therefore important to ascertain whether a carer can cope with the patient once they are discharged, and what support they may need to help them (43,44). The involvement of carers in discharge planning is also important because caring can affect a person's psychological and physical well-being (43).

Older people are usually not consulted about the planning of their intermediate care (9). It can be difficult to develop procedures for the greater involvement of older people because they are far from being an homogenous group when it comes to intermediate care. This is partly because of the sheer diversity of care being provided by this service (7), partly because different people may want different levels of involvement (45), but also because different people have different needs and can experience a range of problems in communicating their needs (25,46,47). It is therefore important to develop means of effectively ascertaining the views and preferences of individual older people and their carers in the provision of intermediate or community care.


## What do the different sources of knowledge show?


## Organisational Knowledge

This section lists and briefly summarises documents that describe the standards that govern the conduct of statutory services, organisations and individuals when discharging older people to intermediate or community care.

Department of Health (2002). National Service Framework for Older People. Supporting Implementation. Intermediate Care: Moving Forward
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4006996&chk=lOXI4C
This document offers guidance to support the implementation of intermediate care services for older people. This includes a discussion of issues such as mental health and learning from good practice, as well as providing a review of the research evidence and some examples of good practice. There is no mention of principles for patient or carer involvement.

Department of Health (2002). National Service Framework for Older People. Single Assessment Process
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en
The single assessment process (SAP) for older people was published in January 2002. The purpose of SAP is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively. This process

advocates a person-centred approach in line with the National Service Framework for Older People, in which "the older person's views and wishes are central to the assessment process". It does not specifically cover Intermediate Care, however. There are problems in implementing this process because of blurred boundaries of responsibility within and between the health and social care staff involved in co-ordinating, assessing and delivering community care (48).

Department of Health (2001). Intermediate Care. Health Service Circular. 2001/001/Local Authority Circular
http://www.dh.gov.uk/assetRoot/04/01/22/69/04012269.pdf
This circular provides the full, detailed definition of intermediate care which authorities are expected to apply, including the criteria that intermediate care is to be a course of therapy or support not lasting more than six weeks. It also gives guidance on service models, professional responsibilities and the factors involved in planning services. The document also describes as "essential" the "close involvement of patients/users and carers in assessment and in drawing up an individual care plan", although no details are given about how this should be achieved.

Department of Health (2001). National Service Framework for Older People
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4073597&chk=4wRxm%2B
The National Service Framework (NSF) for Older People was published on 27 March 2001. It sets new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital. Relevant Standards include Standard Two - Person-centred Care, and Standard Three - Intermediate Care.

Department of Health (2001). Involving Patients and the Public in Healthcare. A discussion document.
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002892&chk=C%2B5rW0
This discussion document summarises the work carried out to develop the proposals in the NHS Plan to create a patient-centred NHS. It emphasises the importance of obtaining and acting on the views of service users.

Department of Health (2000). The NHS Plan: A Plan for Investment, A Plan for Reform
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4002960&chk=07GL5R
The NHS Plan describes a major programme of investment in intermediate care and related services for older people. This document emphasises the importance of obtaining and acting on the views of service users.

National Health Service (NHS) and Community Care Act 1990

http://www.legislation.hmso.gov.uk/acts/acts1990/Ukpga_19900019_en_1.htm

This Act aims to enable people with physical or other needs to live in their own homes. The emphasis is on independence. According to this Act, patients have the right to choose where they go when they are discharged.


## Policy Community Knowledge

This section summarises documents describing proposed structural models for the delivery of policy and improved practice. These documents are published by public policy research bodies, lobby groups, think tanks and related organisations.

Comptroller and Auditor General (2003). Ensuring the Effective Discharge of Older Patients from NHS Acute Hospitals
http://www.nao.org.uk/publications/nao_reports/02-03/0203392es.pdf
This document analyses data relating to delayed discharge from NHS acute care, and makes recommendations for improved service delivery, including discharge planning from the moment of admission, relevant data collection and analysis, the clear definition of professional responsibilities, and joint working between health and social services, including the provision of adequate intermediate care. An increase in service user involvement is also recommended in this guidance.

Stevenson J. & Spencer L. (2002). Developing Intermediate Care. A Guide for Health and Social Services Professionals. King's Fund, London
http://www.kingsfund.org.uk/pdf/DevelopingIntermediateCareSample.pdf
This guide defines intermediate care and describes the policy context for this service. It reviews the research on the effectiveness of intermediate care and offers recommendations on how to develop, implement and evaluate intermediate care in a local care community. This includes practice examples, as well as models of tools and methods.

Scottish Intercollegiate Guidelines Network (2002). Management of Patients with Stroke. Rehabilitation, Prevention and Management of Complications, and Discharge Planning. A National Clinical Guideline.
http://www.sign.ac.uk/pdf/sign64.pdf
This national guideline states that stroke patients and their carers should be involved in discharge planning and care (chapter 5), and "be kept fully informed and consulted at each stage of the [discharge] process" (chapter 7), but there are no details about the nature or content of this consultation, or how it is to be achieved.

Nuffield Institute for Health (2002). Exclusivity or Exclusion? Meeting Mental Health Needs in Intermediate Care. Leeds.
http://www.nuffield.leeds.ac.uk/downloads/mental_health_needs.pdf
This document reports on the current state of intermediate care for older people with mental health problems, and makes a series of recommendations

for more effective practice, including planning and co-ordination of care; the development of appropriate skills; joint working with existing services, and proposals for new services.

Hill M., MacGregor G. (2001). Health's Forgotten Partners? How carers are supported through hospital discharge.
http://www.carersuk.org/Policyandpractice/Research/Health_frgprtns.pdf
This survey of the policy towards carers in 23 NHS Trusts in the north west of England offers a range of good practice recommendations and a checklist to improve the involvement of carers in discharge planning.

## Practitioner Knowledge

This section describes studies carried out by health and social care practitioners, documents relating their experiences regarding the topic, and resources produced by local practitioner bodies to support their work.

Health and Social Care Joint Unit and Change Agents Team (2003). Discharge from Hospital: Pathway, Process and Practice
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4003252&chk=CKj7ss
This "good practice guidance" is designed to help health and social care professionals provide appropriate discharge planning and practice for older people. There are sections on both intermediate care (chapter 6.1) and involving patients and carers (chapter 4). The chapter on patient and carer involvement discusses how to achieve successful involvement, including addressing mental health and communication problems; assessing need; and how to communicate effectively with patients and carers. This chapter also emphasises that patients' and carers' preferences may conflict. A list of common questions asked by patients is also provided, as well as checklists for assessing the preferences and needs of carers.

Intermediate Care & Integrated discharge planning/care pathways (LIN)
http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/IntegratedCare/ChangeAgentTeam/ChangeAgentTeamArticle/fs/en?CONTENT_ID=4049393&chk=i9%2BGvz
The Intermediate Care Local Integrated Network (LIN) was set up by the Department of Health to provide an opportunity for senior staff from public and private organisations to work together on improving intermediate care and integrated discharge planning/care pathways.

Department of Health (2001). National Service Framework for Older People. Good practice examples and case studies: standard three (intermediate care)
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplePromotionProject/OlderPeoplePromotionProjectArticle/fs/en?CONTENT_ID=4002287&chk=4xCeO8

This is a list of practice examples from the Department of Health aimed at providing integrated services for intermediate care. There are no specific references to patient or carer involvement.

Department of Health (2001). National Service Framework for Older People. Good practice examples and case studies: standard two (person-centred care)
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplePromotionProject/OlderPeoplePromotionProjectArticle/fs/en?CONTENT_ID=4002285&chk=f8JgQm
This is a list of practice examples from the Department of Health aimed at ensuring that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social service boundaries. This may include older patients' participation in the planning and delivery of their care.

Devon Social Services & Dementia Voice
http://www.dementia-voice.org.uk/Consultancy/Intermediate_care2.htm
This is a template for providing intermediate care to people with dementia. This includes user involvement issues concerning assessment and consent. Older people with cognitive impairment provide a particular challenge for the principle of user involvement in intermediate care (47).

Vaughan B. Lathlean J. (1999). Intermediate Care. Models in Practice. King's Fund, London
http://www.kingsfund.org.uk/pdf/IntCare_ModelsinPractice.PDF
This document lists and describes a range of intermediate care practice initiatives. The aim is to share problems and successes in order to help inform and develop effective practice in the field of intermediate care. None of the examples refers to patient or carer involvement.

Two studies report on the development of intermediate care services which take into account the views and preferences of individual older patients or carers. One NHS Trust has developed the post of a carer specialist as part of their patient-centred care initiatives (49). The carer specialist works with carers of older people discharged to intermediate care to help them access appropriate information, services and other means of support. The second paper reports the setting up of a specialist "Older People's Support Service" by a PCT to help deliver intermediate care in the community (50). Consultation with patients and carers about their "expectations and views" was a key part of the assessment process. This assessment was then used to produce tailored intermediate care plans for each individual.

Research Knowledge

This section summarises the best available research literature. The focus is on studies undertaken in the United Kingdom, so that the findings are as relevant as possible to the intended audience of the briefing.

**The limitations of the research**

There is almost no research at all on individual patient or carer involvement in intermediate care, either on assessment and discharge to intermediate care, or on the care itself, although representative groups such as Age Concern have been involved in the planning of some services (13). Some research examines the effectiveness of various elements of intermediate care, and this work sometimes refers to patient participation or choice in the planning of care, but it does not examine this feature of service delivery at all (8,15,17-20,51). Also, studies which report patient satisfaction with certain intermediate care services examine this issue from the perspective of patients' assessed needs, rather than their preferences (7). In fact, there is little research evaluating intermediate care as a whole, both because it is a relatively recent service development and because it is an extremely diverse service. This makes it difficult to measure the effectiveness of intermediate care as a concept (2,3). Also, methodologies for evaluating user involvement in health and social care are in their infancy, which means there are few available models on which researchers can draw (7,52). This deficit is recognised by the National Service Framework for Older People (23). Some research from the United Kingdom does address the involvement of individual older users of health and social services, especially in discharge planning and community care services (29,31,33,37,45,46), and the difficulties of evaluating and practising user consultation (7,37,45). Such research has also been conducted in the United States (30,34). This research has implications for the development of individual patient and carer involvement or participation in discharge planning to community care, especially intermediate care, and is therefore considered below.

**What are the issues for patients and carers?**

The principal concerns of patients or carers who want to be involved in the planning of their care are whether they will be able to cope; whether their carers will be able to cope, whether there will be adequate statutory provision for them; where their care will take place, at home or elsewhere; and many practical concerns, such as what will happen regarding cooking, cleaning and shopping (27,33,39,43,44,53). They also have concerns about discharge because hospital care is free, but social or community care may be means tested, thus creating anxiety regarding both money and bureaucracy (49,50). Research from both the United Kingdom and the United States has found that having access to information about their condition, treatment, and available services is crucial to the ability of patients and their carers to contribute to decisions (7,29,30,34,37,43,44,54). They therefore need to be kept informed if they are to be involved in any meaningful way in the planning of their discharge and care.

**Are patients and carers being involved in discharge planning?**

A report into the participation of older patients and carers in discharge planning found that the acute trusts studied considered that these groups had

been consulted, but this perception was not shared by the patients or carers themselves (24). This finding has also been reported by other studies, especially for carers (27,37,43,44,54,55). Carers report that they are often not consulted or kept informed about the discharge process, even though policies are frequently in place requiring the involvement of this group (43,44,56). Other research has found that local initiatives designed to involve older people in decisions regarding their own care did not lead to any actual changes in the services provided. This type of involvement has been described as a form of "tokenism" (7,32,45). However, the views of older patients were sought about their treatment and care in a UK trial of an early discharge and rehabilitation service for older people, and this found that patient outcomes and satisfaction were much improved by this service (39).

Research has found that a "top-down" or paternalistic approach is the norm for discharge planning of most kinds (30,54,57). However, guidance documents advocate a move away from exclusive professional control to decision making which is shared with individual patients and their carers (28,43,44,58). In fact, health and social care professionals think it is important for older patients and their carers to be involved in decisions about their discharge and care (15,27,29). One US study has demonstrated how health professionals considered patients' and carers' expression of their preferences and concerns to be a vital part of the discharge planning process (30). This same study also found that consultation was sometimes being implemented in discharge planning, but its application was inconsistent. Some patients and carers were asked for their views, and these were taken into account in planning discharge and care, but others were not. In the latter case, the care itself sometimes had to be revised, or there were readmissions due to the inadequacy of the post-discharge care (30).

**What are the barriers to the involvement of patients and carers?**
Communication is recognised as an essential part of user involvement (29,30,45,46,58,59), but patients who wish to have a say in decisions regarding their care may be prevented from doing so by several factors. These difficulties include cognitive impairments (10,25,37), the shock or trauma of illness, injury and hospital admission (59), or language difficulties, for example, older people from ethnic minorities who may not speak English (46). The same barriers can apply to the involvement of carers. For example, carers from ethnic minorities are less likely to be consulted than white carers (43,44). There is much literature on aiding communication with older people who have dementia (60), but the research has found that older people with cognitive impairments can also be excluded from intermediate care services for reasons other than communication problems. These may include the focus of intermediate care on short-term rehabilitation for physical illness only, rather than temporary physical or mental problems for patients with mental health needs; the absence of models of intermediate care for this group of patients; the lack of staff skilled in assessing and rehabilitating older people with mental health problems; and funding limitations (25,37,47). The result can be delayed discharge or inappropriate discharge to long-term care (25,47). Policy documents state explicitly that older people with cognitive impairments must not be excluded from intermediate care and that the mental

health needs of older people must be taken into account when planning care (4). However, health and social care professionals also need to assess risk to the patient, and this consideration may invalidate any preferences the patient may have expressed (37).

Patients may also be prevented from participating because they do not feel very confident when dealing with certain professionals. Patients often do not initiate discussions, but wait for prompts from staff before expressing any views about their discharge or care (33,37,59). However, one study of hospital patients identified several approaches that encourage older people to participate in their care. These include showing respect for the patient's opinions and needs, building trust with the patient, and building empathy by taking time to understand a patient's history and their illness (61). According to research from both the United Kingdom and the United States, older people feel more able to express their preferences to "front line" personnel, such as nurses and social workers, than to consultants and doctors (33,34,45). These findings may help determine who should be involved in seeking patients' and carers' views on their care, especially since both UK and US research has shown that intermediate care is largely delivered by professionals other than doctors, such as community nurses, physiotherapists, social workers and volunteers (38, 60}. A patient partnership model for discharge planning developed for, and reported by, a US study found that the best results for the involvement of patients and carers were achieved when nurses actively encouraged them to ask questions and express preferences about their needs and care (34).

Practitioners who seek to involve older patients can therefore experience difficulties in doing so, because illness, impairment, shock, confusion, a lack of confidence, and language difficulties may all prevent adequate communication. The socio-economic background of the patient may also influence their willingness to express views about their discharge and care. Patients from lower income groups may be more likely to accept decisions and be reluctant to express their own preferences (37). Some patients may also have unrealistic expectations about what they can do, or what services can be delivered (29,59).

## User & Carer Knowledge

This section summarises the issues raised by patients and carers in relation to this topic, both as described by the literature and as defined through local consultation.

In one survey most of the older people and their carers who were asked about their involvement in discharge planning said that they wanted to be involved, and felt that their views had been taken into consideration (45). Other studies, including the Fife user panel project, have also found that patients and carers feel they have a role to play in their discharge and care, and want to be involved as much as possible (24,30,33,55,62). Carers have also said that

they want to be asked whether they would be able to cope, and they want to be given as much information as possible on the illness, and to be assured that the necessary support services will be in place (44). However, some older people do not want to play an active role in decision-making about their discharge or care (33,37,63), can be reluctant to express their views (50,62), or are happy to subordinate their involvement to family members, other carers or health professionals (29,33,37,45,59). This is especially the case for frail or very ill older people (37,45,54,62).

This diversity of opinions from users is reflected in a recent study on the involvement of older patients and their carers in planning discharge from acute care (45). Some older people volunteered opinions about their discharge, while many others were happy to do so when prompted (45). It also found however that almost a quarter of this sample did not want to be involved at all (45). Almost half of this "passive" group also had the poorest health, which may have affected their willingness to be involved (45). However, older patients can tend to have rather low expectations of care and services, and can feel very dependent on professional decisions (37,62). Many patients and carers ultimately allow their decisions to be governed wholly by the professionals involved in their care.

Some older people value the help of their informal or formal carer in providing input into discharge planning, in addition to, or in place of, their own involvement (37,45). They feel that their carers articulate their needs effectively and act as an important intermediary between themselves and health or social services. However, some older people say they are unhappy with family or carers playing this role because their views can be unrepresentative of their own wishes (29,30,64). This in turn can create a problem of negotiation and implementation for health and social care staff involved in the planning of care. Professionals therefore need to seek the opinions of both carers and patients. The New Zealand "family meeting" model for the discharge of older patients, a consultation which involves the patient, family member(s) and professional staff, has been found to improve patient satisfaction, but only in cases where patients wanted to be involved, and only where the actual purpose and scope of the meeting was made very clear to the patients and their family (63).

## Useful Links

This section lists sources of information relevant to professionals who work within this field, and may also be of value to service users.

Age Concern
http://www.ageconcern.org.uk/
Age Concern is a registered charity which offers support to all people aged 50 and over in the UK. The organisation works to influence public opinion and government policy about older people. It also provides fact sheets.

British Geriatrics Society (BGS)
http://www.bgs.org.uk/
The BGS is the only UK professional association of doctors practising geriatric medicine. The BGS issues guidelines and policy statements relating to intermediate care.

Help the Aged
http://www.helptheaged.org.uk/default.htm
Help the Aged provides information to older people about aspects of their life and health, including the process of discharge from hospital http://www.helptheaged.org.uk/Health/HealthServices/Coming_out_of_hospital/_default.htm

Intermediate Care
http://www.jiscmail.ac.uk/lists/INTERMEDIATE-CARE.html
The intermediate care mailing list has been developed for professionals allied to health and social care who are directly involved or interested in the development of intermediate care services within the United Kingdom.

Joseph Rowntree Foundation
http://www.jrf.org.uk/
The Joseph Rowntree Foundation is one of the largest independent social policy research and development charities in the UK. This includes work on intermediate care, the views of older people on community care planning, and projects on older people shaping policy and practice.

National electronic Library for Health. NSF for Older People - Standard 3: Intermediate Care
http://www.nelh.nhs.uk/nsf/older_people/standard3.htm
This website provides links to a range of resources about Intermediate Care, including legislation, guides, research and models for practice. Many of the documents are produced by the King's Fund.

**Related SCARE briefings**

Aiding Communication with People with Dementia
http://www.elsc.org.uk/briefings/briefing03/index.htm

# Acknowledgements

Reference List

(1) **Pawson R., Boaz A., Grayson L., Long A., Barnes C. (2003). Types and Quality of Knowledge in Social Care. Knowledge Review 3. Social Care Institute for Excellence (SCIE). Title link:** http://www.scie.org.uk/publications/knowledge.asp **[Accessed 25 April 2005]**.

This document analyses and defines the different types of knowledge and information which may inform social care research and practice.

(2) **Carpenter I., Gladman J.R.F., Parker S.G., Potter J. (2002). Clinical and research challenges of intermediate care. Age and Ageing, 31 (2), 97-100.**

This is a commentary on the issues and challenges involved in applying research evidence to intermediate care.

(3) **Vaughan B., Lathlean J. (1999). Intermediate Care: Models in Practice. King's Fund. Title link:** http://www.kingsfund.org.uk/pdf/IntCare_ModelsinPractice.PDF **[Accessed 25 April 2005]**.

This document describes a range of current models for intermediate care.

(4) **Department of Health. (2002). National Service Framework for Older People. Supporting Implementation. Intermediate Care: Moving Forward. Department of Health. Title link:** http://www.dh.gov.uk/assetRoot/04/06/56/94/04065694.pdf **[Accessed 25 April 2005]**.

This report reviews current developments and issues in intermediate care for older people.

(5) **Stevenson I., Spencer L. (2002). Developing Intermediate Care: a guide for health and social services professionals. King's Fund, Title link:** http://www.kingsfund.org.uk/pdf/DevelopingIntermediateCareSample.pdf **[Accessed 25 April 2005]**.

This guide considers definitions of and policy for intermediate care; summarises the research evidence relating to this system of care; and makes recommendations on how to develop a local intermediate care plan.

(6) **Department of Health. (2001). Intermediate Care. Health Service Circular. 2001/001/Local Authority Circular. Department of Health. Title link:** http://www.dh.gov.uk/assetRoot/04/01/22/69/04012269.pdf **[Accessed 25 April 2005]**.

This document provides full guidance on the definition of intermediate care and the responsibilities of professionals and statutory agencies.

(7) **Andrews J., Manthorpe J., Watson R. (2004). Involving older people in intermediate care. Journal of Advanced Nursing, 46 (3), 303-310.**

This paper explores the concept of intermediate care and to identify trends and existing evidence of user involvement in care. It also suggests a possible way forward for the development of a more 'user sensitive' approach.
Abstract available
http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15066111

(8) **Martin G.P., Peet S.M., Hewitt G.J., Parker H. (2004). Diversity in intermediate care. Health & Social Care in the Community, 12 (2), 150-154.**

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(10) **Nancarrow S. (2004). Improving intermediate care: giving practitioners a voice. Journal of Integrated Care, 12 (1), 33-41.**

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(11) **Glasby J. (2002). Acute concerns. Nursing Older People, 14 (7), 6.**

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(12) **Asthana A., Halliday J.E. (2003). Intermediate care: its place in a whole systems approach. Journal of Integrated Care, 11 (6), 15-24.**

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(13) **Age Concern, British Geriatrics Society. (2002). Implementation of the National Service Framework and intermediate care seen from geriatricians' and older people's perspectives: results of two national surveys; reasons for optimism, reasons for concern. British Geriatrics Society. Title link:** http://www.bgs.org.uk/homepages/BGS%20Age%20Concern%20joint%20doc.pdf **[Accessed 25 April 2005]**.

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(14) **Bernhaut J., Mackay K. (2002). Extended nursing roles in intermediate care: a cost benefit evaluation. Nursing Times, 98 (21), 37-39.**

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(20) **Unsworth J., Hardy L., Binks E. (2000). District nursing involvement in intermediate care. Journal of Community Nursing, 14 (3), 21-24.**

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(22) **Royal Commission on Long Term Care for the Elderly. (1999). With Respect to Old Age: Long-term Care - Rights and Responsibilities. TSO. Title link:** http://www.archive.official-documents.co.uk/document/cm41/4192/4192-00.htm **[Accessed 25 April 2005]**.

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(23) **Department of Health. (2001). National Service Framework for Older People. Department of Health. Title link:** http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4073597&chk=4wRxm%2B **[Accessed 25 April 2005]**.

The National Service Framework (NSF) for Older People was published on 27 March 2001. It sets new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital.

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(25) **Nuffield Institute for Health. (2002). Exclusivity or Exclusion? Meeting Mental Health Needs in Intermediate Care. Nuffield Institute for Health. Title link:** http://www.nuffield.leeds.ac.uk/downloads/mental_health_needs.pdf **[Accessed 25 April 2005]**.

This report outlines key findings and suggestions from a programme of seminars and consultations attended by people involved in delivering intermediate care, especially to people with mental health needs.

(26) **Glasby J., Littlechild R., Pryce K. (2004). Show me the way to go home: a narrative review of the literature on delayed hospital discharge. British Journal of Social Work, 34, 1189-1197.**

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(27) **Glasby J. (2003). Hospital discharge : integrating health and social care. Abingdon, Radcliffe Medical Press**.

This book describes and reviews the policy and research literature relating to discharge planning in the UK.

(28) **Scottish Intercollegiate Guidelines Network. (2002). Management of Patients with Stroke. Rehabilitation, Prevention and Management of Complications, and Discharge Planning. SIGN. Title link:** http://www.sign.ac.uk/pdf/sign64.pdf **[Accessed 25 April**

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This paper describes nurses' views of the participation of older patients in their discharge planning.
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(32) **Beresford P., Carter T. (2000). Age and Change. Models of Involvement for Older People. Joseph Rowntree Foundation. Title link: http://www.jrf.org.uk/bookshop/details.asp?pubID=278 [Accessed 25 April 2005]**.

This report offers practical guidance and ideas to increase the involvement of older people.

(33) **Jewell S. (1996). Elderly patients' participation in discharge decision making: 2. British Journal of Nursing, 5 (17), 1065-1071.**

This article is the second in a two-part series describing a study exploring patient participation in discharge decision making.

(34)  **Bull M.J., Hanson H.E., Gross C.R.  (2000). A professional-patient partnership model of discharge planning with elders hospitalized with heart failure. Applied Nursing Research, 13 (1), 19-28.**

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(35)  **Bull M.J., Kane R.L.  (1996). Gaps in discharge planning. Journal of Applied Gerontology, 15 (4), 486-500.**

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(36)  **Shah P.N., Maly R.C., Frank J.C., Hirsch S.H., Reuben D.B.  (1997). Managing geriatric syndromes: what geriatric assessment teams recommend, what primary care physicians implement, what patients adhere to. Journal of the American Geriatrics Society, 45 (4), 413-419.**

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This is the government's national strategy document for carers.
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(44) **Holzhausen E. (2001). "You can take him home now". Carers' experiences of hospital discharge. Carers National Association. Title link:**
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HomeNow.pdf **[Accessed 25 April 2005]**.

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(48) **Cornes M. (2004). Inside multi-disciplinary practice: challenges for single assessment. Journal of Integrated Care, 12 (1), 3-13.**

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(49) **Negus J. (2004). Improving care of older people through intermediate services. Nursing Times, 100 (28), 34-36.**

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(54)  **Cornes M., Clough R. (2001). The Continuum of Care: older people's experiences of intermediate care. Education and Ageing, 16 (2), 179-202.**

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(55)  **Barnes M., Cormie J. (1995). On the panel - good hospital discharge. Health Service Journal, 2 March, 30-31.**

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(56)  **Hill M., MacGregor G. (2001). Health's Forgotten Partners? How carers are supported through hospital discharge. Carers UK. Title link:**

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(57) **Mountain G., Pighills A. (2003). Pre-discharge home visits with older people: time to review practice. Health and Social Care in the Community, 11 (2), 146-154.**

This paper reviews the available evidence to make a case for a reconsideration of the practice of undertaking pre-discharge home visits with frail older people.
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(60) **SCARE 3. (2005). Aiding Communication with People with Dementia. Social Care Institute for Excellence (SCIE). Title link:**
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