Intermediate Care and Older People

Building a case for continuous care
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1 Introduction

1.1 Overview

This report presents the findings of a two-year research study of older people’s experiences of using intermediate care services which involved the voluntary sector. The research was carried out as part of the Help the Aged Intermediate Care Programme for Older People, a three-year service development programme funded by the Department of Health and the Active Community Unit of the Home Office. The programme, which ran between 2001 and 2004, piloted innovative ways of including volunteers and the voluntary sector in intermediate care. As part of the programme seven pilot projects were established in different locations across England to develop partnerships between local voluntary agencies and NHS-led intermediate care teams.

This research focuses on older people’s experiences of using the seven pilot projects and the wider support systems in which they were embedded.

1.2 What is intermediate care?

Fundamental to the reforms set out in the NHS Plan (Department of Health 2000) is the desire to find new ways of working between health and social care that will remove outdated institutional barriers and provide seamless services. Services should no longer stand alone. Intermediate care has been at the forefront of attempts to redraw the boundaries between health and social care. Launched as a key component of the National Service Framework for Older People (NSFOP) (Department of Health 2001a), intermediate care aims to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely hospital discharge and maximise independent living. Although intermediate care is not specifically targeted at older people, this group forms the great majority of its users.

According to a progress report by the Department of Health (2002), a thousand flowers have bloomed as different professionals (social workers, community nurses, occupational therapists and physiotherapists) have come together to work in intermediate care.

Intermediate care, by its very nature, cannot be the sole preserve of any single profession, organisation or sector. It is not just about health care, [n]or social care, [n]or housing – it is about all of these things and more and how professions and organisations can work together to make the core principle of delivering person-centred care a reality . . . It is, quintessentially, about partnerships between organisations and professions and this is another key area where development is needed, so that services become fully integrated. (Department of Health 2002)

The way in which different intermediate care services and teams are organised locally varies a great deal (Martin et al 2004). Figure 1 illustrates the professional mix of two of the intermediate care teams that were involved in this study. However, to meet the standard definition set by the Department of Health (2001b) intermediate care should be regarded as describing services that meet all the following criteria:

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

(b) 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

(c) have a planned outcome of maximising independence and typically enabling patient/users to resume living at home

(d) are time-limited, normally no longer than six weeks and frequently two weeks or less, and

(e) involve cross-professional working, with a single-assessment framework, single professional records and shared protocols.
1.3 The role of the voluntary and community sector in intermediate care

In 2001, the Department of Health and the Active Community Unit of the Home Office earmarked funding to develop the contribution of the voluntary and community sector in intermediate care. According to the Department of Health (2001b), the voluntary sector can support intermediate care in myriad different ways: for example, by helping people regain confidence as part of rehabilitation, by providing social support as part of supported discharge packages, or by taking up a residual support role as an intermediate care service ends.

As recipient of a Department of Health Section 64 grant for £688,000, Help the Aged established seven pilot projects across England to develop and research practical ways of integrating volunteers and voluntary sector services in intermediate care. The pilot projects were developed in partnership with local voluntary agencies. Partner agencies were selected through national competition and were asked to demonstrate how older people would be involved in managing the work and any previous history of joint working with the statutory sector. Shortlisted agencies were invited to make a presentation to a final selection panel comprising staff from Help the Aged and older people who had recently formed a National Advisory Group to oversee programme delivery. The successful projects were:

- **The Calderdale Intermediate Care Partnership Project**, based in West Yorkshire and hosted by Age Concern Calderdale
- **Connections**, based in Bournemouth and hosted by Help and Care
- **Healthy Homes Rapid Response Care and Repair Service**, based in Sefton Merseyside and hosted by Anchor Staying Put
- **Homeward Bound**, based in Coventry and hosted by Extra Care
- **RUSTIC (Rural Support Team for Intermediate Care)**, based in Essex and hosted by the Dengie Project Trust
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- **STEPPS**, based in Liverpool and hosted by PSS (Personal Social Services)

- **Coral (Community Outreach for a Return to Active Life)** For this project, Help the Aged entered into a partnership agreement with North Surrey Primary Care Trust (PCT) and directly employed a voluntary sector project officer.

It was expected that staff from the voluntary sector projects would become full members of their local NHS intermediate care teams, whenever possible co-locating in the same office space.

Each pilot project was allocated a budget of £60,000 over two years and was expected to:

- **appoint a volunteer co-ordinator**

- **provide access to a team of fully trained volunteers** recruited to work with older people who are receiving intermediate care services, or who require extra support in the residual period following the end of intermediate care

- **offer voluntary sector care management** and access to a dedicated service co-ordinator to look at how services provided in the local voluntary sector can be better integrated as part of an individual package of intermediate care alongside the input of other professionals (e.g. social workers, community nurses, occupational therapists, physiotherapists)

- **provide a rapid-response community alarm and support service** through Help the Aged SeniorLink. Each project was given a stock of community alarm units which could be plugged in to an existing phone socket in the older person’s home and connected to a national call centre within one hour of referral. As well as a pendant or device for summoning help in emergencies, the 24-hour service could also support health and social care staff working in intermediate care, who could ask call centre staff to help with the delivery of the care plan itself: for example, to make a call to remind the older person to take medication or just ring to check that all is well if no professional was scheduled to visit. At the end of intermediate care, the older person had the option of either returning or keeping the device. Projects could also access other Help the Aged flagship services including HandyVan (for minor repairs and security aids) and SeniorLine, a free telephone information and advice service

- **undertake development work** to identify gaps and difficult issues in existing local voluntary sector service provision which, if remedied, could further support intermediate care and relieve pressure on hospital beds.

In addition to the core tasks described above, the projects were also given scope to develop specific good practice ideas. For example, Extra Care in Coventry piloted a unique scheme based on monthly ‘get-togethers’ to keep in touch with older people once they had been discharged from intermediate care. In doing so, these initiatives further contributed to the new service models that have emerged following the NSFOP:

*The real achievement of those responsible for planning and delivering successful intermediate care services has been to put into practice apparently simple ideas in a very complex organisational and professional environment.*

(Department of Health 2002)

In order to distinguish the work of the Help the Aged Intermediate Care Programme from mainstream voluntary sector activity and its so-called ‘general prevention’ work, a stated criterion was that all clients must be aged over 60 years and have been assessed as eligible for intermediate care. In practice, this meant that all referrals to the pilot projects had to come from local council- or NHS-led intermediate care teams. Thus, what united all the pilot projects was a focus on developing integrated working.

Indeed, what distinguishes intermediate care from mainstream care is the requirement that a whole
range of different services is pulled together quickly and, if necessary, provided to a far greater degree than is usually possible. For example, if an older person lives on their own and develops bronchitis he or she may need access to care then and there (medical, nursing and personal) on the same day he or she takes to bed – not ten or fifteen minutes of care offered days or weeks later. It can be this delay in providing care, and then not providing enough care, which leads many older people to be admitted to hospital or care homes unnecessarily (that is, not for medical reasons). Intermediate care aims to address these gaps or delays:

Properly developed and implemented [intermediate care] will enhance appropriateness and quality of care for individuals but will also have a significant impact on the health and social care system as a whole by making more effective use of capacity and establishing new ways of working. (Department of Health 2002)

An important element of the Help the Aged Intermediate Care Programme was to make available additional resources to the voluntary sector so that like its partners in health and social services, it too could develop capacity for a ‘rapid response’. This was the core theme of the work developed by Anchor Staying Put in Sefton, Merseyside. The agency developed the Healthy Homes Scheme, a rapid-response home safety service which was geared up to respond to referrals from the hospital within 24 hours, thus facilitating a speedy and safe discharge home for older people about to receive intermediate care. This is the only scheme out of the seven projects that did not operate using volunteers.

1.4 A blueprint for voluntary sector integration

Given that Help the Aged contracted with different and unrelated providers (local voluntary groups) to develop its intermediate care work, the seven pilot projects evolved at very different rates and in quite diverse ways. For example, a number of the projects could draw on an existing pool of volunteers (Age Concern Calderdale, Help and Care, Extra Care). By contrast, other projects had to recruit volunteer teams from scratch. Despite the differences between the pilot projects, coherence and focus were maintained in the programme through a series of performance management targets set by the Department of Health. These were monitored by an intermediate care programme manager employed by Help the Aged. Each pilot project was expected to:

- contribute to the intermediate care plans of 129 older people
- recruit 24 volunteers (with the exemption of Anchor Staying Put)
- attend quarterly meetings
- produce quarterly monitoring reports.

Over the lifetime of the programme, the seven pilot projects recruited 138 volunteers (target 140) and worked with 1,263 older people (target 903), who were referred to the projects mostly by local NHS-led intermediate care services.

However, there was also a desire to understand outcomes that were much less easily discernible than those encompassed by the performance management framework. Fundamental to the programme was a vision of an integrated service in which the needs of the older person were paramount and the contribution of the voluntary and community sector was seamlessly interwoven with many other health and social care services. Figure 2 illustrates this vision diagrammatically as a possible ‘care pathway’.

This is the vision that Help the Aged set out to deliver through its Intermediate Care Programme for Older People. In this report, we draw on the views of older people and other key stakeholders to explore to what extent this level of integration and person-centred care delivery was achieved in practice.
Figure 2  Example of an intermediate care pathway demonstrating the integration of services provided by the voluntary sector

Mrs Smith is admitted to hospital following a fall. She has broken her leg.

Referral and allocation
On admission, ward staff refer Mrs Smith to the hospital social work department and to the co-ordinator of the hospital intermediate care team. Monitoring of Mrs Smith’s good progress on the ward suggests that the hospital IC co-ordinator is best positioned to lead on the single assessment process and to act as care manager.

Single assessment
The findings of the assessment are that Mrs Smith has excellent rehabilitative potential and that her needs could best be met by an intermediate package of care provided in her own home.

Care planning for intermediate care
The Intermediate Care Plan requires the co-ordination of many different professionals and agencies [including professionals and care staff not directly employed or seconded to the hospital intermediate care team]. All are working to ensure that Mrs Smith will be fully independent within the next six weeks. The input of the voluntary sector is mapped out below.

Community nursing  Occupational therapy  Physiotherapy  Home care

Voluntary sector
During the home visit conducted as part of the single assessment process, it is noted that Mrs Smith is in danger of falling again because her carpets are uneven. The hospital IC team voluntary sector co-ordinator telephones the local HandyVan scheme, which now has procedures in place to allow people meeting the eligibility criteria for intermediate care to be given priority. The HandyVan visits Mrs Smith’s home within 24 hours of the phone call from the intermediate care team, thus permitting plans for early discharge to say on track.

The assessment also shows that Mrs Smith is expected to make a full recovery within the next six weeks. As part of her intermediate package of care, the Help the Aged SeniorLink service has been contacted and now has procedures in place to provide for rapid access to a community alarm unit for a period of six weeks. The protocols also state that the co-ordinator of the community alarm scheme will receive a copy of the care plan and will telephone Mrs Smith to check that she is OK during the periods when she is alone.

The intermediate care volunteer team is also involved in care package. A volunteer accompanies Mrs Smith the first few times she goes shopping. Walking to the shops is one of Mrs Smith’s rehabilitation goals set by the team physiotherapist. Also, for the first few days after Mrs Smith arrives home from hospital, a volunteer keeps her company in the afternoon when no health and social care professionals are scheduled to visit. It is also planned that once Mrs Smith is discharged from intermediate care, a volunteer will continue to visit every day for a further three weeks to check on progress.

Six weeks later, Mrs Smith hears the news that her free social care (personal help with washing and dressing) organised by the hospital intermediate care team is to be withdrawn. The voluntary sector co-ordinator refers Mrs Smith to her local pensioners’ Information and Advocacy Service, a member of whose staff visits Mrs Smith at home to help clarify the situation and provide advice on all aspects of the wider community care system.
2 Involving older people

2.1 Overview
This section considers the research aims, the rationale for the study, what is already known about intermediate care, and the methodological approach that was used to gather older people's views, including some of the challenges that were encountered.

2.2 Research aims and rationale
In May 2002 Help the Aged commissioned a team of researchers to undertake a two-year study of older people’s experiences of using the seven voluntary sector pilot projects and the wider intermediate care systems in which they were embedded. The overall aims of the research were:

- to map, across seven different localities, intermediate care pathways and outcomes from the perspective of older people, carers, volunteers and frontline professionals from voluntary and statutory sectors
- to consider the relationship of the voluntary sector to intermediate care and the wider continuum of care
- to explore issues relating to integration and partnership working between the statutory and voluntary sector in the delivery of intermediate care
- to develop findings for best practice.

In commissioning the study, Help the Aged was clear that the views of older people had to be at the heart of any approach. There was concern that while the vision and rhetoric concerning intermediate care, rehabilitation and partnership working in the NHS Plan could impact favourably on outcomes of care for older people, older people might also find themselves landed with poor-quality services that provide no effective rehabilitation and, at worse, inadequate medical cover (Robinson et al 2000):

There should be comprehensive and ongoing evaluation of intermediate care as it develops. Help the Aged believes that older people should expect to receive access to equal-quality services wherever they live. (Help the Aged policy statement 2001)

2.3 What is already known about intermediate care?
The Department of Health has commissioned evaluations of many aspects of intermediate care (see www.prw.le.ac.uk/intcare) and many descriptions now exist of the variety of services labelled ‘intermediate care’ and the localisation of such resources (in other words, the way in which ‘top-down’ ideas and guidance become translated at local level to address particular pressure points). Reporting of intermediate care has often addressed targets set by central government (e.g. hospital bed days ‘saved’) and has not always critically appraised experiences; only modest evidence has been collected about intermediate care from older people’s perspectives (Petch 2003).

2.4 Methodology
The starting point for the research was the seven Help the Aged pilot projects. These were used as a window or ‘port hole’ through which the research could view the wider intermediate care system. The researcher spent one week immersed in the everyday life of each of the seven projects, attending meetings, shadowing and observing practice.

At the heart of the approach were in-depth qualitative interviews with older people who had direct experience as intermediate care service users. Five older people were interviewed in each of the seven pilot sites (n=35). The five participants were approached on the basis that they were the five most recent people to have been assisted by the Help the Aged pilot projects. As in wider intermediate care, there was an expectation that the voluntary projects would work with people for a maximum of six weeks. This was not a fixed rule, more a guideline, in that if more support
was required, then it could be provided. Three carers were also involved in the study and were interviewed at the same time as their relative. The low number of carers involved in the study reflects the fact that most of the recipients of intermediate care in this study were living alone.

The interviews were open-ended and designed in such a way as to encourage participants to tell their own story in their own words. Whenever possible the researchers avoided the jargon of intermediate care (e.g. instead of asking, ‘Would you describe the care you received as person-centred?’ they would say, ‘Can you tell us about the care and support you received?’).

Topics covered in the interviews included the following broad areas:

- the story behind why the person was involved with the intermediate care team
- the services provided and the people who delivered it (who visits?)
- how care was arranged, and the extent to which people were consulted
- what information was given
- what support was provided
- whether it made a difference
- what happened when intermediate care ended.

In addition to the interviews carried out with service users, we also approached other key stakeholders for their views on how the voluntary sector projects were working in practice. They included voluntary sector project directors (n=7), voluntary sector co-ordinators (n=7), volunteers (n=8) and staff working in NHS-led intermediate care (n=7). These interviews were also open-ended, focusing on:

- perceptions of what the voluntary sector could bring to intermediate care
- how partnerships and cross-sector relationships were working
- plans for future development.

Documentary evidence was gathered in each site on local intermediate care services. The research team also had access to the monitoring reports produced by the pilot projects for Help the Aged, including access to 100 case studies that included anonymised case records held by the voluntary projects.

The emerging findings of the research were fed continuously into the programme’s development and ‘reality-checked’ at every opportunity with practitioners and older people attending quarterly meetings of the Programme Advisory Group. Ethical permission was obtained from the Central Office for Research Ethics Committees. All names have been changed in the reports.

Three particular challenges emerged in the study.

1. By definition, older people using intermediate care services are likely to be unwell. Just out of hospital, they may also be anxious and distressed. Any research had to bear in mind their vulnerability and be prepared for interviews to be cancelled, curtailed or difficult.

2. The terminology of intermediate care, rehabilitation and care plans is professionally dominated. We found it helpful to have a range of alternative phrases (e.g. convalescence) and to be able to have a ‘cast list’ of who was who in the team (e.g. Jane was the occupational therapist, Sally the district nurse).

3. New services build on pre-existing contexts and past relationships. It can be difficult to assess the impact of any new initiative without knowing something of the background. For example, a new project in the voluntary sector may be part of a well-established organisation. However, if it is a group’s first funded activity, the organisation will shape its direction. There is considerable difference between voluntary sector groups, even if they are classified together.
3 Older people’s experiences of intermediate care

3.1 Overview
This section explores older people’s experiences of using the seven Help the Aged pilot projects and the wider intermediate care systems in which they are embedded. It also considers the outcomes of intermediate care from older people’s perspectives and makes the case for continuous care.

The National Service Framework for Older People is bound together by four principles:

- person-centred care
- promoting health and active life
- timely access to specialist care
- whole-system working.

According to the Department of Health (2002), these principles, which form the subheadings for the discussion that follows, should underpin the planning and delivery of intermediate care services and provide a yardstick against which they can be assessed.

3.2 Person-centred care
Person-centred care helps to ensure that older people are treated on the basis of their individual needs, circumstances and priorities. Person-centred care attempts to put the needs of service users first and to regard organisational or professional issues as secondary. Essential to this approach is a robust assessment process and the involvement of older people and their carers in decisions about the care to be delivered.

In the service user accounts, there was good evidence to suggest that a highly person-centred approach was being taken by the volunteers and voluntary sector services. Though there were some exceptions, these were few and far between.

RUSTIC service user 2: I never got turned down once. Every time I asked, you know, [RUSTIC] sorted me out. That’s what you need...

Healthy Homes service user 3: Well, I’m very happy with [Healthy Homes]. Because I think that anything I’d have asked for, [the handyman] would have dealt with it . . . He gave me his mobile number and said, ‘Ring any time’. That helped.

Many participants seemed to feel they were ‘in a pickle’. Very often this did not relate to medical matters but to practical issues of home and domestic life. The ability of the voluntary projects to be flexible and to deal with these issues, things that ‘really mattered’, no matter what they were, was something that was greatly appreciated,

Researcher: When [the volunteer co-ordinator] had a chat with you, what information did she give you?

Homeward Bound service user 2: I can’t remember now. There’s so much going on, and it’s been a bit of a pickle and [the scheme co-ordinator] helped me with the fridge. I don’t know how I’d have coped, because I haven’t got any children . . . I’ve got a younger brother, but he’s on a frame.

STEPSS service user 4: She [the volunteer co-ordinator] helped me in every way. She was marvellous. I couldn’t have survived without her. She’s been marvellous. Nobody, even the doctors, is as good as she is to me. Even the specialist. Nobody could be like her. She is out of this world for me. I think without her I’d be dead.

Researcher: So would you say that RUSTIC has been a help to you?

RUSTIC service user 1: Well, they help by doing the actual work . . . They introduced the gardener and he did a smashing job outside. He cleared up all the mess, you know. So I just walked out there and saw it and he’d done it all, and he’d tidied it all up. It was fantastic.
In addition to being flexible, the projects were recognised as playing a crucially important role in providing back-up:

**RUSTIC service user 2:** It’s more or less knowing that you’ve got somebody there as a back-up. I think that is what people need when they come out of hospital, because you’re very down and you can’t get about like you could. You just don’t feel yourself for some time, you know. It was knowing that I could phone them [RUSTIC], that was the main thing . . . I really got stuck for my prescription one day, things like that . . . I think there’s more of them wanted, really. Especially in rural places like this. There are loads of people coming out of hospital and you just feel completely on your own. And you’ve got somebody at the end of a phone, that’s how I felt. I think they’ve done everything I wanted them to do. I think they’re marvellous, I really do.

**STEPSS service user 2:** Just having somebody with me is a big comfort . . . I’m not particularly lonely, because I mean you’ve the telephone and television, and that. But just knowing that somebody’s there is the big thing, you know. If you put your hand out, you like to know that somebody’s gonna get hold of it. You know – in a friendly fashion.

The ‘warmth’ and informality of the voluntary sector’s approach was a key theme in many of the older people’s accounts:

**Researcher:** You were saying that you were crying when you came home from hospital and that [the volunteer] was able to change that?

**Coral service user 1:** The very first time I was out there sunbathing and she came around the corner and I heard the feet. And as she turned the corner we both burst out laughing and we never stopped until she went, honestly. That’s the truth.

**Homeward Bound service user 2:** Oh, [volunteer], he was a treasure. Very helpful and very nice, yes. You feel, well, he helps you to feel better, I reckon. That’s what I think, anyway.

**STEPSS service user 3:** [the volunteer co-ordinator] was very, very good. I mean, we’re friends now. Started out as my social worker and we’re friends now . . . Lovely, you know. As I say, she is willing to do anything that I ask her to do.

There were also examples of the voluntary projects going well beyond the call of duty to put the needs of the person before organisational or professional considerations:

**Researcher:** So what happened when you came out of hospital – when you came home? What happened?

**RUSTIC service user 2:** Oh, when I came home they were supposed to have let [the volunteer co-ordinator] know about me and they hadn’t done. And so I phoned up myself and of course [RUSTIC] don’t usually work on a weekend but [the volunteer co-ordinator] offered to come out.

**Researcher:** So you actually came home over the weekend?

**RUSTIC service user 2:** I came out on a Friday, you see. And it was late Friday afternoon. That was the problem.

**Researcher:** So you contacted RUSTIC yourself?

**RUSTIC service user 2:** Yes. I contacted them . . . I spoke to [the volunteer co-ordinator] and she sent me all the papers. And I’d never had to have anything like this before and it was new to me . . . I was thankful for it, because she picked up all my shopping for me and prescriptions, and I really made use of her.

Despite the high degree of person-centredness evidenced in voluntary sector activity, there was little to suggest that this was underpinned by a robust single-assessment process (where one service can make use of the information collected by another) or that older people had actively been involved in their assessments:

**Connections service user 5:** While I was still in hospital, somebody from [the intermediate care team] came along and that was a nurse, a male nurse, and he was supposed to have got a complete picture of what was wrong with me from the sister
at the hospital, but I wasn’t in on the interview so what was said I don’t know … Nobody was finding out if I could do any washing, if I could get to the shops …

Researcher: Did the nurse or somebody come and have a chat with you? What happened when you got home?

RUSTIC service user 3: My son brought me home. I can’t remember what happened. I think they all started the day after, wasn’t it? I think somebody did talk to me in the hospital. But I can’t quite remember what the talk was about. I just think it was a general chatter.

Researcher: So were you asked whether you wanted to go to [the residential intermediate care scheme]?

Homeward Bound service user 2: No, at the time the hospital sent me, you see.

Because the older people were not fully involved in discharge planning and assessment, it seemed to them that services and volunteers would materialise out of thin air:

Coral service user 1: I didn’t choose Coral. They arrived.

Coral service user 4: Whilst I was in [the community hospital] they came in and asked me what the situation was … I said it’s not too bad. I can get out, it’s just the shopping … He made a note of it … and when I came [home] I had two carers who used to come in twice a day. They were the ones that put me in touch with Coral. And from then on I’ve had [the volunteer].

STEPSS service user 3: No one told me about STEPSS. Doctor suggested I could have a – like – a home help … and the next thing was [the volunteer co-ordinator] came along, and then [the volunteer].

Interestingly, participants rarely interpreted this lack of involvement as particularly problematic:

Researcher: Were you consulted about what you needed?

Calderdale service user 5: No.

Researcher: Would you like to have been consulted?

Calderdale service user 5: It is not something I’ve thought about really. It’s something I’ve left to the professionals. They’re the experts really.

Researcher: Did they discuss what you wanted?

Coral service user 3: Well, I don’t know what I do want, really.

Researcher: You weren’t sure, then?

Coral service user 3: Not sure then. Not sure now. I guess it was agreed that [the volunteer] should come in.

One participant pointed out that patients really needed to know what services were available before they could ask about them:

Healthy Homes service user 5: We don’t know what services we can get … People say unless you ask they won’t tell you.

3.3 Promoting health and active life

According to Department of Health (2001b, 2002) intermediate care should promote independence at every available opportunity and should encompass:

- a planned outcome of maximising independence, typically enabling patients/users to resume living at home
- a range of opportunities for older people to remain healthy and independent
- evidence of helping older people to realise their full potential as well as regaining health.

Although there was no evidence of service users being party to goal-setting or having clearly defined rehabilitative outcomes, such as those linked to physiotherapy or occupational therapy, it was clear that an enabling philosophy and a commitment to active ageing had permeated intermediate care in many of the projects:

Researcher: What choice of activities did you have while you were in [the residential intermediate care scheme]?
Homeward Bound service user 2: They keep you occupied, mentally and physically. There were get-togethers. Gardening. Flower-arranging. And exercises every morning. It did help you keep going.

Researcher: Were there any other activities that you enjoyed?

Homeward Bound service user 2: Some weeks we had wheelchair dancing. Well, I didn’t know what that meant. I’d got no idea, never heard of it. But they took us down in the wheelchair and you sit in the wheelchair and dance. You’re pushed round with the mostly lovely people. Better than just sitting about doing nothing, which isn’t me at all. I’m nearly 88 now, but I’ve always been so active.

It was also evident that volunteers could play an especially important role in supporting rehabilitation and confidence-building:

Researcher: Why did STEPPS stand out?

STEPSS service user 1: Nobody else bothered that way. Coming out and going out with me for a start. Took me all over the place. That’s how I felt better. Bound to, isn’t it, you know, when you’ve never been out hardly? It was more or less twelve months without going out.

Coral service user 4: You see, I’ve always, until now, walked to Safeway’s and back, and I’ve enjoyed the walk, but it is getting a bit much now. Especially when the weather’s bad. So the first time [the volunteer] came with me, she just took me in the car and we walked round the shops. Did the shopping and back again. I think we did that for two weeks and then she said, ‘Next week I want you to bring your trolley and we’ll carry on as you normally would on your own, and see how we get on.’ That’s how it was.

Coral service user 2: As I say, she comes and she sees me up and down the stairs. She gives me the hope that she’s going to be able to take me out. Something to look forward to.

The older people interviewed seemed to appreciate the way in which rehabilitation provided by the voluntary sector was at one and the same time an opportunity to do everyday and enjoyable things.

Homeward Bound service user 2: The experience is that it’s a very happy place and you are very well cared for there, and they do all they can to get you on your feet. The morning exercises and the place is lovely. Like a nice hotel – five star!

3.4 Timely access to specialist care

According to the Department of Health (2002) older people benefit from high-quality specialist care as much as anyone else and must not be denied access on the basis of age. Appropriate and timely intervention when required is important. The development of intermediate care is about delivering appropriate care — ensuring that older people have access to the right services, in the right place at the right time; it must not be perceived as a device for denying older people the care they need. Built-in arrangements for obtaining specialist assessment, diagnosis and treatment should therefore be established.

Barring the time spent in hospital and occasional references to outpatient visits or visits to the GP, there was little if any reference to doctors being part of intermediate care. Furthermore, care and contact provided by doctors was the most likely aspect to be criticised by participants:

STEPSS service user 4: The [volunteer co-ordinator] hasn’t been able to do anything with the medical profession… There was nothing they could do, you see, so they let me go in instead to the hospital wing to where the retired people go.

Homeward Bound service user 1: Where my bed was in the ward I could see through into the sister’s office. And [the doctor] was arguing with another man about something on the X-ray thing. I’m almost sure it was mine.

Researcher: You knew they were talking about you?

Homeward Bound service user 1: Anyway, the doctor comes in and says, ‘Have you been out of bed since you came in here? I’m in from Friday to Monday now.’ He said, ‘You’re going home now, there’s nothing wrong with you.’
Researchers: So what was the outcome? Did you have the operation?

Homeward Bound service user 1: No. The truth of the matter was they didn’t want to operate, because of my chest. It just annoys you that you can’t get answers out. They treat you like children.

Researchers: And how are you coping now?

Coral service user 2: With difficulty.

Researchers: Why’s that?

Coral service user 2: Well, because I can’t bend. That’s the one thing. Can’t put my tights on. My neighbour comes in and puts my tights on… I do try. I should have asked the surgeon when I saw him last Wednesday, ‘How long is it before I can bend?’ The doctor gave me a prescription: tights, stocking things. Well, they were absolutely impossible to put on.

There was no evidence of arrangements for obtaining specialist assessment, diagnosis and treatment. Recipients of intermediate care seemed to be subject to the same waits and frustrations as every one else:

Researchers: Do you drive?

Coral service user 3: I do drive. For about fifty years, fifty-odd year, but I can’t see to drive properly now. I’ve got cataracts coming – so they tell me. I’m on the list to go to the hospital… I used to read a lot. I even read the paper every day, and read a lot, but I don’t now. Well, I can’t see to read without a magnifying glass.

Researchers: I believe you were in hospital for a while?

Coral service user 1: Ten months. I had two operations. The first was a failure. The first was in March and from the beginning I said there was something wrong. I could tell there was. And in the end I insisted to the physio that she should make me an appointment for me to have an X-ray, which she did. And they said, ‘Oh yes, there’s something slightly wrong here, but come back in a month’s time’ – which I never understood because it wasn’t going to get better, was it? I waited about a month and I went back, and they said yes, I would have to be operated on. And three to six months’ wait – which my son immediately took up and said that that was very unfair, because they had made a mistake and it should be counted as the same operation. I shouldn’t be put on the waiting list. It was getting worse and worse.

People were also waiting for other services and equipment which could impede rehabilitation and progress:

Calderdale service user 1: It seems as though you have to get to that stage where you can’t manage any more before anybody does anything.

Researchers: How long have you been waiting for your shoes?

Calderdale service user 1: Well it’s about nine weeks now.

The fact that the Healthy Homes project on Merseyside was geared up for a rapid response and able to speed up the provision of aids and adaptations was something that surprised and impressed participants who were able to access the service:

Healthy Homes service user 4: The district nurse said, ‘Why haven’t you got the hand-rail up?’ and I said, ‘We are way down the list.’ So she said, ‘Why don’t you phone [Healthy Homes]?’ And she got through for me and she sat there while I spoke to them. And within a very short space of time the rail was up. If we’d have been waiting for the council, we’d still be waiting now.

This service was, however, limited to only one of the seven project areas. In the other areas, intermediate care clients did not receive any special treatment in terms of local council waiting lists.

Connections service user 5: The male nurse said that there was going to be so much deterioration that you’ll need a stair-lift. So we’ll put in for the stair-lift straight away, because you will have to wait something like a year.
3.5 Whole-system working

According to the Department of Health (2002), older people are at their most vulnerable at transition points in care, so services must work in partnership, with shared responsibility for meeting all the needs identified. That shared responsibility is particularly important in intermediate care. The ‘whole-system’ approach should mean exactly that – an inclusive approach that recognises the contribution of all partners in the local system. The principle of whole-system working should also extend to effective integration with other services to ensure that intermediate care does not develop in isolation.

In the service user accounts there was evidence of a great deal of multi-professional involvement. However, older people were very confused about who the different people were.

**STEPSS service user 2:** There are different people coming in and most of the time I couldn’t remember who they were, or what they were doing . . . There was a nun came around and she put her hands on my head and started to bless me and the next thing was, she said, ‘Have you anything to confess?’ I said, ‘I’m not of your faith.’ ‘Oh,’ she said, and she ran away. I had to laugh when I got home. But you see there are all these people who come round . . .

**Connections service user 5:** Now I can’t remember what happened but in the evening the joiner came and I had four visitors. One was a dentist, an assistant dentist, I think . . . I’d had some teeth out. One was a nurse, but she had been working in a nursing home as a care assistant. Now that’s nice for a qualified person to do that . . .

None of the older people interviewed made explicit reference without prompting to being referred to and seen by a member of a voluntary sector intermediate care team. Most often, the volunteer co-ordinators were assumed to be from social services:

**Researcher:** So what happened when you came home? Did anybody come to see you?

**RUSTIC service user 1:** Well, you know it was all arranged by social services. They came along and said, ‘Do you want any assistance for the garden?’ and I did really, because we’re supposed to keep the gardens up . . . The chap they provided, he made quite a nice job of the garden. And [the volunteer] came over every week and did the hoovering. That’s the main thing. I mean, I can do some of the dusting and stuff . . .

**STEPSS service user 4:** How did they come? It might have been through the – what do they call them? I can’t remember what they’re called. I think it’s the social worker.

**Researcher:** When you were at [the residential intermediate care scheme], what happened there?

**Homeward Bound service user 2:** I was received very nicely by the head. I think she’s the head carer – I don’t know. She took me up to my room and it was lovely.

In the older people’s accounts, there was very little knowledge or memory of any kind of care-planning or care co-ordination. While partnership working may have been operating between professionals it was not apparent to older people themselves. Overall, services appeared to arrive in a fragmented fashion and seamless service was not in evidence.

**Homeward Bound service user 2:** I’ve got my carers coming in, and they do my leg, but that’s it.

**Sefton service user 5:** She was very good. She was for your hands. She was a physiotherapist, I think . . .

**RUSTIC service user 2:** When the [volunteer co-ordinator] came, somebody had already asked somebody to come and clean for me and that. But I needed somebody to do some shopping for me . . .

**Researcher:** So, when you came home, somebody from STEPSS came to see you at home and have a chat with you?

**STEPSS service user 2:** Well, there were so many people, to be honest, I’m confused because there were people who came to see about how I was coping all right with the food and the cooking,
and there was other people coming to see me about the cleaning.

In terms of care co-ordination, the volunteer co-ordinators would often act as advocates for their clients, pulling in the medical and nursing care that was sometimes missing:

**Researcher:** Did anyone from the hospital come to see you when you came home?

**RUSTIC service user 2:** No, nobody . . . I had problems afterwards and [the volunteer co-ordinator] got on to the nurse. She asked for the nurse to come . . . I was thankful and she went down to see my doctor and sorted it out from there. As I say, without [the volunteer co-ordinator] I would have been in a muddle. It was the right help that was the point.

On the whole, care management proved something of a mysterious process from a service user perspective:

**Researcher:** What did [the volunteer co-ordinator] provide?

**STEPSS service user 4:** I don’t know. It’s hard to say, but she got in touch with different people for me . . . just different people to come and do things.

Not surprisingly, most older people were not aware of the standards that could be expected in intermediate care, especially those that advise good multi-disciplinary and multi-agency working:

**Connections service user 5:** I suppose there is normally a review process but I’m not sure how it works in this area. Whether somebody comes to you after one week, three weeks . . .

**STEPSS service user 1:** They were fantastic, they were. But you’re only allowed [a] certain [number of times]. Seven. You count how many weeks it works out and when you’ve finished you’ve got [no more support].

However, participants nearly always assumed it was their own age and illnesses that confused them, not the lack of good-quality information about the system:

**Researcher:** The information that [the NHS intermediate care co-ordinator] gave you when she spoke to you in hospital – did you find it sufficient? Was it clear?

**STEPSS service user 2:** Well, I expect it was at the time, but as I say, I’ve got short-term memory [loss] now. Through these illnesses, because of the lack of oxygen to the brain . . . the memory goes so that you find somebody says something and that’s it, a couple of seconds actually. And the next thing – you’ve forgotten what it was.

Indeed, in getting to grips with the system, personal experience seemed to be the best teacher, rather than leaflets or other information:

**STEPSS service user 2:** I knew nothing at all about this sort of thing until I ended up in hospital, for the third time – not the first time, but the third time. And slowly I started to realise that there were different people coming to see me and that they each had different types of job . . . It’s a bit of a shame that you’ve got to be ill before you find out these things.

### 3.6 Outcomes

Despite the shortcomings identified above, virtually all of the participants in the study were extremely impressed and pleased with the care they had received from the voluntary sector and the wider intermediate care system:

**STEPSS service user 3:** Anything to do with the STEPSS you can put down ‘excellent’, all the way down.

**Researcher:** So, did you feel that there was any part of your care that could have been improved?

**Homeward Bound service user 3:** No. I don’t think so. No. I’m not a critical person anyway. I’m always happy with what I’ve got. Never ever complain, about anything. I’m so grateful for what I’ve had and what I have now with the care. No, it’s a lovely place and you can’t help but get a bit better . . . I was jolly glad of it [intermediate care]. They help put you on your feet again, the atmosphere and the care, the food and the lovely lounge to sit in. It does help you to get better. And they are real carers, aren’t they? They are, and the nurse and everything.
From participants’ perspectives, intermediate care was strongly linked to two main outcomes: first, it got you ‘sorted out’; second, it gave you the impetus ‘to keep going’.

**Researcher:** So would you say that intermediate care service was of benefit to you?

**Homeward Bound service user 2:** That place up there? Absolutely. Absolutely good. You can’t very well spend a fortnight going into hospital and then come straight back here [home]. You have to get yourself sorted out.

**Coral service user 3:** Just walking up and down the garden helped you keep going . . .

Because friendships had been made and the services were so highly valued it is not surprising that many older people were very concerned at the prospect of their intermediate care coming to an end. As noted earlier, intermediate care is limited to a maximum of six weeks.

**STEPSS service user 2:** The post office is two blocks down the road, but it’s the main road. A busy road, and I’m on the other side so I have to cross the road. I have to stop three or four times on the way there to get my breath. It’s just having somebody with me is a big comfort, because it’s quite frightening. You know, when your legs are getting weaker. Never in my life have I ever had trouble with my legs, but now I’ve put weight on, which is one of the things that has happened since I came out of hospital – I have put weight on, and my legs are feeling the strain. I suppose with the dizzy turns the legs get weaker. It’s nice. It really is good to have somebody and I’m so happy with that. In fact I’m worrying now, to be honest, what’s going to happen when her turn of visits comes to an end.

**Researcher:** How are you managing now that you’re at home?

**RUSTIC service user 1:** I don’t know if I can cope properly. That’s the problem, isn’t it, really? If everybody left me to myself, I wouldn’t be able to cope properly . . . [RUSTIC] have been very helpful and I would miss them if they, well, stopped. I don’t know whether social services would provide me with anything, or whether I would be fully prepared to pay costs if possible.

**STEPSS service user 4:** I don’t know what I would have done without [the volunteer co-ordinator]. She’s been a real godsend. I’m so unhappy that she won’t be coming any more . . . I just wish her boss would have allowed her to stay longer.

**Researcher:** When intermediate care services eventually end, how do you plan to manage?

**Coral service user 2:** It’s having to, isn’t it?

Older people reported how they had been concerned about what would happen to them at the end of intermediate care. While nearly all the participants in this study felt that they had been able to manage when their intermediate care had ended, they had been left with many unmet needs. In their accounts there was also a sense of sadness concerning what is perceived to be the inevitability of impending isolation, disability and decline. These were assumed to be a normal part of the ageing process and after intermediate care there had been no personnel providing support to challenge this.

**Researcher:** So how are you getting on now?

**Coral service user 3:** I’m getting on o.k. I can still feel it, but let’s face it, I’m ninety. It’s going to take longer, isn’t it? It’s going to take longer, but it’s not stopping me from getting around. I do get around and I can carry on here and do my own washing, cooking, the same as normal.

**Researcher:** And have you been able to go shopping since [the volunteer] left?

**Coral service user 3:** No. I haven’t tried. I haven’t tried . . .

**Researcher:** And now that you’re home, how do you manage?

**Healthy Homes service user 3:** I manage with difficulty, but it’s better than being in hospital . . . I’m a bit of an independent type . . . I empty my own commode in the night, I sleep in there [other downstairs room]. I have a wash myself, except my legs. I have to have them done. And I like to make my own tea, because I wake up so early, I always have. You see I’ve been on my own 30 years and I’m used to being on my own, and independent
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... I’m managing with more difficulty now. I have to cling on to [home]. I feel weak. I feel as if I’m — oh, I don’t know, crumbling away, like. It’s the osteoporosis and the headache.

STEPSS service user 2: When I came out of hospital, I knew I was getting better and I felt better, and so you tend to think, ‘Well I don’t need [intermediate care].’ It was nice of them to ask and you start getting a bit independent again, you know. Unfortunately in my case it hasn’t sustained, it’s just gone down hill slowly, slowly.

Researcher: And does anybody call you now from STEPSS? Do you get any calls for a chat? Does anybody call you to find out how you are?

STEPSS service user 2: Maybe they do, but then I’m not ill really. I’m just here now, you know. As long as I’ve got the inhalers and that. I can speak to anybody on that machine [community alarm] if I feel I need anybody. Other than that I don’t really think that I need anybody to keep checking up on me, you know.

3.8 Conclusion

Older people were very positive about their experiences of using intermediate care which involved the voluntary sector. There was evidence of practice that was person-centred and multi-professional. Although older people were not party to goal-setting or clearly planned outcomes for rehabilitation, there was much evidence that promoting independence and active ageing had permeated the culture of intermediate care.

However, participants in the study had only a very limited understanding of the standards they might expect as part of intermediate care. There was little evidence of practice based on shared-assessment processes or information exchange with the voluntary sector and older people were confused by the number of different professionals coming and going. Care often seemed to arrive by chance and was fragmented, with different people/services taking on responsibility for different tasks and, indeed, parts of the body. Nevertheless, intermediate care was a viewed as a lifeline, especially the support provided by volunteers.

Overall, intermediate care was associated with two main outcomes from older people’s perspectives: ‘getting sorted out’ and being able to ‘keep going’. However, beyond intermediate care it appeared that future support was not so assured. For most of the older people interviewed in this study, ‘once the flower had finished blooming, the outlook was not particularly rosy’ (voluntary co-ordinator).
4 Can volunteers and the voluntary sector make a difference?

4.1 Overview

In this section, we contextualise the accounts of the older people interviewed, drawing on documentary evidence and the accounts of other key local stakeholders (volunteers, project co-ordinators, and directors and staff working in NHS-led intermediate care teams). We tease out the specific contribution of volunteers and the voluntary sector to intermediate care. We explore the process of joint working and the barriers that stand in the way of achieving a genuinely integrated service. This is not an academic exercise, as the findings have many implications for risk management and improved practices, especially in respect of the supervision and management of volunteers.

It is significant that in July 2005 the Government announced its intention to launch a White Paper designed to deliver integrated health and social care systems (Department of Health 2005). To this end, a task force will be established to identify the obstacles that stand in the way of effective partnership between the voluntary sector and health/social care services. This initiative will build on earlier guidance which required the NHS and the community and voluntary sector to sign up to local compact agreements (Department of Health 2003).

The overall aim of the combined measures is to promote a strong business relationship between the voluntary and public sectors and to support the voluntary and community sector’s increasing role in contributing to health service and social care delivery. This is seen to be complementary to the voluntary and community sectors’ distinct roles in relation to promoting health and social inclusion, and in lobbying and advocacy (Department of Health 2003, 2005).

The measures reflect that, as demand for health and social care grows, volunteers and the voluntary sector are increasingly looked to as part of a potential solution. At the same time, the government’s strategy for an ageing population (HM Government 2005) puts forward plans to develop a new organisation to encourage more volunteering in later life.

4.2 The moving ice field

It was assumed that the role of volunteers working in the projects should be flexible, to meet individual needs, and should complement rather than replace the work of the wider NHS/local council intermediate care team. Project information, for example, envisaged that volunteers would provide short-term support and undertake a range of tasks including preparing the house and helping people settle back home after a stay in hospital; pet care; shopping; and accompanying people on hospital appointments and other outings.

In the older people’s accounts this flexibility was something that was greatly appreciated and a person-centred approach was evident. However, while the volunteers and the projects were responding to the needs of their clients, they were also under pressure to respond to the needs of the wider intermediate care system.

**RUSTIC volunteer:** I know for a fact that people stay in hospital for a lot longer than they need to, because there isn’t social services, you know, to provide that care any more. And so I’m just glad to be able to help to bridge that gap, really.

Statutory services are well practised in defining explicit criteria to delineate their role: for example, whether giving baths is a social services or district nurse responsibility (Cornes and Clough 2001). However, the voluntary projects in this study, because they were often new to work in this area, had no such rules or tradition, such as that illustrated below:

**Intermediate care team physiotherapist:** How it essentially works is that patients are referred to us from the hospital for supported discharge. We are able to take patients [for] up to
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A six-week period, so we’ve got to identify that they’ve a rehab goal, that they’re not a care issue – because we’re obviously not social, we’re not care, we’re rehab.

As a result, the projects would often find themselves pressurised into filling the gaps left by the ‘moving ice field’ that is statutory health and social care provision in a climate of resource constraint. Negotiating the ice field and defining exactly what ‘complementary’ meant in practice proved to be one of the key sources of tension between the projects and local statutory agencies. An extract from a Quarterly Reflection Report written by one of the voluntary sector project managers illustrates this uncertainty:

At one point the intermediate care team was experiencing significant staffing problems and the [voluntary sector] worker was approached by the team manager about taking on additional responsibilities, which included managing other members of the team and undertaking a liaison role with primary care teams. This change would have significantly affected the [voluntary sector] project, taking a large amount of time away from one-to-one work with clients.

The voluntary sector’s contribution to saving the NHS ‘bed days’ was most clearly visible in terms of its troubleshooting role, filling the gaps left by statutory provision:

Mr J was ready for discharge. However, his return home was delayed because the hospital transport service needed 48 hours’ notice. The volunteer agreed to take the client home the following day. The hospital-to-home transport included provision of basic food stores and a volunteer who sat with Mr J for one and a half hours until he had settled in. (Case study extract)

Other local voluntary sector projects that were far longer-established than the Help the Aged partnership projects had fixed boundaries, often defined by their funding agreement. For one older person, the result of this was that she received support from two voluntary agencies involved in the home-from-hospital process, with one volunteer turning up to do her shopping and another to do the dusting.

The need to delineate responsibility in this way is a major barrier to seamless service, but without such boundaries services can be pushed to breaking point. One of the main reasons why the Help the Aged voluntary projects were able to be so person-centred was because they were not running to full capacity and their funding was reliable for the period of the project. In the early days, especially, referrals were often few and far between. The projects were not well known and other intermediate care staff were cautious of making referrals as the projects had yet to build trust. Fewer referrals meant that volunteers and their co-ordinators could provide a ‘Rolls-Royce’ service, spending lots of time with each client. As things took off and referrals started to come in, it became much harder to maintain such a level of service:

RUSTIC volunteer: I think volunteers have much more time. And I mean, although we’re allocated and we go for an hour and if you’re there an hour and a half, and they want to chat, which sometimes they do, that’s o.k. . . . whereas the professional carers, they don’t have the time. They’re just in to do a job, whereas we can be doing our job and, or whatever, and chatting as well. So, I mean, we don’t just sit down and do nothing, but even if we did it wouldn’t matter, because it would help them to have somebody to talk to.

4.3 ‘Dis-integrating’ services

Each voluntary sector project developed a very different relationship with its local statutory sector intermediate care service. In two of the sites, the voluntary sector workers were based in the hospital sharing the offices of the intermediate care team itself. They were perceived as honorary members of the team and accorded many of the rights enjoyed by the full team, such as the sharing of information, attending case conferences, joining in with home assessment visits and other aspects of team life.
In the other sites, a far more traditional relationship between the statutory and voluntary sector was established. Here, the voluntary sector projects existed as separate entities, geared to accepting referrals from the physically distant intermediate care teams. The most frequent reason given for not including the voluntary sector in the main intermediate care team base was shortage of office space. However, in areas with a only limited history of joint working there was also a sense that the voluntary agency needed to prove its trustworthiness and worth before being acknowledged as a genuine partner.

Although office sharing or co-location gave rise to a veneer of integration, this did not translate into practice at the level of an individual older person’s care plan. Within the intermediate care teams, each profession(al) tended to use their own paperwork and to set their own specific goals and objectives of care. There was no overarching care plan and patients or clients tended to be passed between different members of the team, including those from the voluntary sector.

Across all the sites, the voluntary sector tended to be involved either when the patient or client was assessed as requiring low-level (support as opposed to nursing and therapy) or at the very end of the intermediate care pathway, when nursing and therapy staff were about to withdraw. This explains why, from the user perspective, doctors and nursing care were often linked only to the earlier parts of the story.

The district nurse visited the [volunteer co-ordinator’s office] to discuss the possibility of Mrs K being supported by a volunteer as the intermediate care team were reducing their visits. (extract from volunteer co-ordinator’s notes)

The rationale for marginalising the voluntary sector at the end of the care pathway or periphery of intermediate care was two-fold.

First, the voluntary sector has increasingly seen its role in terms of the social model of rehabilitation (Le Mesurier and Northmore 2003). This recognises that although people may be physically better at the point at which they discharged from NHS care, they may still need support to recover the confidence to take up previous activities and to reconnect fully with social and community life. It seems that from an NHS perspective social rehabilitation is often perceived to be the ‘icing on the cake’ and, as such, somehow less important than the more physically focused approach provided by professional therapy staff.

Second, as one intermediate care team nurse manager pointed out, by involving the voluntary sector at the point at which nursing and therapy staff are about to withdraw it becomes possible to stretch the time-frame in which care and support can be provided. Government guidance is that intermediate care should not be provided beyond a six-week period. Help the Aged criteria suggested that voluntary support should also be time-limited to about six weeks, but that this should be flexible. What happened in practice was that older people would often receive six weeks of statutory intermediate care followed by a further six weeks of voluntary intermediate care.

By deliberately ‘dis-integrating’ the service, as shown in figure 3, practitioners were acting in the best interests of their clients, securing for them 12 rather than just six weeks of care. This is an important point, as service integration is nearly always assumed to be an unquestionable good despite the paucity of research evidence to support this (Kharicha et al 2004).

Among the voluntary project co-ordinators there was also a sense that referrals were often made at the point at which the client was ready to go home, and as such an afterthought rather than a partnership.

Few examples emerged of volunteers working alongside nursing and therapy staff in intermediate care. Moreover, because nurse and therapy managers often purposefully dis-integrated the service to find ways of stretching the six-week rule, this suggests that this may be too tight a time-frame for rehabilitation and
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Figure 3 A dis-integrated intermediate care pathway

Referral to the intermediate care team (ICT) co-ordinator
Possible referral to either...

Assessment by ICT physiotherapist
Assessment by ICT nurse
Assessment by ICT occupational therapist

CARE PLAN
CARE PLAN
CARE PLAN

EXIT STATUTORY INTERMEDIATE CARE

Referral to Coral
Assessment visit

Support plan

EXIT VOLUNTARY INTERMEDIATE CARE

6 weeks

12 weeks
recovery. The accounts of older people in this study seem to suggest that even 12 weeks may be too tight and that what is needed in most cases is low-level continuing care. A note from a case file makes the point succinctly: ‘Mrs S required continual intermediate care services.’

Indeed, there is growing research evidence to support this conclusion:

It is of concern that the new intermediate care services are being planned and delivered as short-term, brief contact services . . . The gradual decline and high mortality observed in the patients in this study suggests that longer-term surveillance with repeated contacts might be a more appropriate service model for frail older people. (Young et al 2005)

4.4 Implications for volunteers

As noted above, because voluntary sector activity was located at the end of the intermediate care pathway, volunteers and their co-ordinators would often find themselves working in isolation from the rest of intermediate care team. Only rarely would intermediate-care community nurses, social workers and therapy staff participate in the assessment and follow-up visits carried out by the volunteer co-ordinators. The perception was one of having ‘referred’ or passed on the patient to the voluntary scheme. There was therefore little sense of the volunteers being an integral part of intermediate care package or, if one existed, the multi-disciplinary care plan. In most of the sites the patient would receive a wholly separate care plan (or ‘visit plan’) detailing the voluntary component.

[An assessment visit carried out by the volunteer co-ordinator] established that while Mrs K could now get herself up, washed and dressed, she was still very tired and frail. She was beginning to regain her appetite but did not have the strength or enthusiasm to prepare her own main meal. It was agreed that the volunteers would visit daily at lunchtime to provide assistance and motivation. (extract from volunteer co-ordinator’s report)

The corollary of this is that the volunteers could find themselves working in isolation from nursing and therapy staff in situations where the client or patient was still very poorly and where, it might be suggested, the level of support required might actually have been greater than that provided. Extracts from the case notes kept by the volunteers and the project co-ordinators illustrate this:

Mrs A stated seriously to the volunteer that she would take her own life . . . Mrs A has run out of her barrier cream. [The volunteer] stopped off at the GP’s and collected a prescription. Mrs A was pleased to have the cream as her skin was red-raw and near to bleeding . . .

Mrs B fell in her toilet and bruised her arm . . . Queried why all the falls . . . Mrs B not looking forward to us withdrawing. She still does not want to go to church – wants to go in her own time under her own steam.

Mrs C feels trapped in her flat and said she was scared in case there was a fire. She can’t get down the stairs . . . Says she is fed up with herself . . . Can’t use the sock aid and feels she cannot go out without being properly dressed.

Mr D’s wife is in hospital and has been diagnosed with a terminal illness. Mr D looking very tired and frail. Mr D reports that he has lost over a stone in eight weeks.

Mrs E was admitted to hospital in a very frail condition five weeks previously due to a severe urine infection. A referral was made to the volunteer co-ordinator] following a discussion with the intermediate care team social worker. It was requested that a volunteer provide monitoring and support. No other services were to be involved.

In one of the projects we undertook a survey of volunteer recruitment and retention (Manthorpe et al 2003). This found that most (85 per cent) of the volunteers had a nursing background, perhaps suggesting that a high level of skill and professionalism is required to survive as an intermediate care volunteer. Indeed, it was not uncommon for the volunteer co-ordinators to opt to provide support themselves rather than
Can volunteers and the voluntary sector make a difference?

place their volunteers inappropriately. In turn, the fact that many of the statutory intermediate care teams did not include a social worker meant that the volunteer co-ordinator role could easily step across into that territory. Overall, the picture was of volunteers and volunteer co-ordinators often playing a far more critical role in intermediate care than they were given credit for. So for some older people, the volunteers and their co-ordinators were the jam and sponge as well as the icing on the top of the cake.

4.5 Towards a comprehensive intermediate care service

One of the key aims of the programme was to develop voluntary sector care management to secure a comprehensive intermediate care service (Cornes et al 2003). Voluntary sector project staff had not only to co-ordinate and manage their own ‘in-house’ services, but also to reach out to secure and co-ordinate the work of other local voluntary service providers. This, it was hoped, would provide a flexible and creative response that could dramatically increase the range of services available to older people receiving intermediate care.

The Connections project in Bournemouth was dedicated to developing the voluntary sector care management approach and therefore did not manage a team of volunteers directly. An ‘advocacy support worker’ was based in the hospital working alongside the intermediate care team to make links with a wide range of local voluntary services on behalf of clients or patients. For example, Mrs S, a woman of nearly 90, was admitted to hospital following a collapse at her local community hall where she was playing bingo. The occupational therapist from the intermediate care team referred Mrs S to the advocacy and support worker, who:

- installed a SeniorLink community alarm for a six-week period
- arranged for her nephew to provide support with shopping and cleaning until longer-term arrangements could be made
- arranged for the Roots team to get to grips with Mrs S’s very overgrown garden
- arranged for a benefits check, which secured Attendance Allowance
- arranged for the HandyVan to visit to make adaptations necessary to make indoor mobility safe
- took Mrs S to view and try equipment at the Visually Impaired Society
- arranged for a Care Direct volunteer to accompany Mrs S to her outpatient appointment.

The other six projects found voluntary sector care management more difficult. First, recruiting and directly managing teams of volunteers proved so time-consuming that there was very little time to focus on other things. The key implication was that, as in the Connections model, care management needed to be understood as a full-time job in its own right. Furthermore, the project co-ordinators across all the sites found it very difficult to enable older people to receive services that were not provided in-house or by their own volunteers. This appeared to be a result of the way in which the voluntary sector increasingly tends to be funded. Indeed, the Help the Aged programme itself fell foul of this problem. To ensure that resources were used for the purpose which they were given, access criteria were set which dictated that the projects could work only with older people who had been assessed as eligible for NHS- or local council-led intermediate care. In turn, nearly every other voluntary project or service the project care managers tried to use had a similar rule set up by an external funding body which served to exclude the older person being supported by the Help the Aged projects.
Even other in-house services were sometimes difficult to use. For example, in rural Essex many older people who were receiving support from a Dengie Project Trust (RUSTIC) intermediate care volunteer might also have benefited from being able to use the Dengie Project Trust day centre. However, the day centre was funded by social services and hence open only to people referred by social services.

It was therefore difficult to help older people access the right sort of support from the many services in a local area; also, there were clearly barriers to partnership working within sectors as well as across them. Furthermore, although some areas were better served than others, no single geographical area appeared to have put all the pieces of the jigsaw in place.

The following quote illustrates what this could mean for individual older people:

The volunteer carried out six visits in the ten days. These began with the volunteer doing all the preparation and clearing up, but within days Mrs K was beginning to start the preparations before the volunteer arrived and this progressed by the end to her having a cup of tea ready for the volunteer’s arrival. She enjoyed the social aspects of the visits immensely and expressed that she would have liked the social visits to continue. Unfortunately there is no befriending scheme in this area which we could refer on to. (extract from volunteer case notes)

### 4.6 Key messages for practitioners and team working

For frontline practice, the key message to emerge from the study concerns the importance of constantly monitoring and reviewing the development of any multi-professional team. Within intermediate care, there was a sense in which the partnership with the voluntary sector developed in a way that was not originally intended. The corollary of this was that volunteers and volunteer co-ordinators were working in isolation from the wider team when a far greater degree of integration and supervision may have been more appropriate.

The overall implication is that procedures for ‘care management’ or ‘nursing process’ review need to extend far deeper into the intermediate care pathway, even though the only missing input may relate to the services provided by the volunteers. However, such a recommendation will clearly pose series challenges to a system that is already over-stretched and, indeed, to the very concept of intermediate care as a time-limited service.

### 4.7 Key messages for service commissioners

The fact that the voluntary sector contribution is associated with low-level support and regarded as the ‘icing on the cake’ means that it is rarely taken seriously by commissioners, who assume it to be the most easily dispensable and least important component of the intermediate care service.

Nearly all of the Help the Aged partnership projects found it impossible to secure financial support from the local primary care trust or other external commissioners to help them continue beyond the pilot phase. This mirrors the experience of the Age Concern social rehabilitation programme, which was also unsuccessful in establishing any service contracts.
during the lifetime of the pilot programme (Le Mesurier and Northmore 2003, p14).

The voluntary sector would appear to have some way to go before it is taken seriously as a genuine partner, and certainly the key message to emerge from this work is the need to consider joint or integrated financing of any pilot project from day one. Indeed, as current practice creates barriers not only between but within sectors, making it difficult for older people to access the care and support they need, funding mechanisms as a whole may need to be reviewed.
5 Determining the way forward

Help the Aged failed to achieve its objective to create an integrated intermediate care service, with voluntary sector activity seamlessly interwoven with the input of other health professionals and services. Instead, volunteers and the voluntary sector projects operated on the periphery of the intermediate care pathway, in order to extend the time-frame in which support could be provided. In essence, the projects acted as a further ‘step-down’ in the hospital stay/statutory intermediate care/voluntary intermediate care pathway.

As evidence mounts to support the view that intermediate care may not be the most appropriate model for frail older people (Young et al 2005) there will inevitably be further service reconfigurations. What this study would seem to demonstrate is the potential for the voluntary sector to position itself as a key provider of low-level continuing care. This is not just about prevention or getting people back on their feet, but about enabling older to ‘keep going’ and stay ‘sorted out’: in the words of one participant (RUSTIC service user 3), ‘somebody to expect each day’.

According to Stevenson (2005), moves to mainstream intermediate care will see the end of stand-alone projects. Instead:

The pattern of future care, especially for older people, will be one in which joint commissioning arrangements (and greater partnership working) commission well-resourced health and social care locality teams. Such teams could bring together a full range of professions and skills, generalists and specialists, underpinned by a large number of trained rehabilitative support workers, able to respond flexibly and quickly to people’s changing needs, and offer continuity of care. With a single point of contact, an open door approach, pro-active and shared assessment and reassessment, access to rapid diagnostics, assistive technology, and good care planning and care management, we may see a revolution in care for older individuals.
References


## Appendix  Statistics for each pilot project

(at 18 September 2003)

[Intermediate Care: Appendix]

ACC = CALDERDALE INTERMEDIATE CARE  
COR = CORAL  
CON = CONNECTIONS  
HH = HEALTHY HOMES  
HB = HOMeward BOUND  
RUS = Rustic  
STE = STEPSS

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*Note* As part of the Programme additional work was carried out in the area of intermediate care but this did not relate to the seven pilot projects directly. This work 'benefited' a further 356 older people and involved placement of 277 SeniorLink units and 79 HandyVan visits.
Recent titles from Help the Aged

The Evaporation Effect
This report is the final evaluation of the Help the Aged Intermediate Care Programme for Older People, drawing attention to the hardship caused by the ‘evaporation’ of intermediate care after a matter of weeks, when the need is clearly for continuing care.

£8.00 ISBN 1-84598-017-4

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What is life really like for disadvantaged older people living in the UK today? This report, featuring full-colour graphs and photographs, shows how people dependent on a state pension cope with daily living costs; the extent of isolation, limited mobility and restricted access to essential services; it looks at low quality of life; at the scarcity of employment and learning opportunities; and at how our society tacitly supports the institutionalised ageism within our health and social care systems. The voices of older people support the call for an end to the injustice that remains entrenched in our society.

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How can we ensure that care-home residents enjoy good quality of life? This extensive report, produced by Help the Aged in partnership with the national Care Forum and the National Care Homes Research and Development Forum, presents direct testimony from residents, relatives and staff on the highs and lows of living in a care home today. It urges a new, patient-centred rather than process-driven approach, focusing on meaningful activity and shared decision-making, in order that the care home can become a community of those who live there, those who work in it and those whose relatives are residents.

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Perceptions of what constitute the everyday essentials are, for many older people, startlingly modest. As this research report shows, people in some of the most disadvantaged sections of society expect very little of life and do not regard themselves as being deprived, or as living in poverty. In older age, as in their earlier existence, they make do with very little and accept the limitations dictated by their financial circumstances. Through the voices of older people, Necessities of Life reveals the true impact of low incomes on quality of life for senior citizens living in the United Kingdom – one of the world’s richest economies.

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When Help the Aged set up its Intermediate Care Programme for Older People, its aim was to establish an integrated service in which the needs of the older person came first and the contribution of the voluntary and community sector was seamlessly interwoven with that of the health and social care services. Volunteers were able to fill the gaps left by statutory provision and, according to statements from service users, made a dramatic difference to the social rehabilitation of frail older people recovering from illness. This report makes a compelling case for continuing care, but the current attitude of service commissioners does not bode well for the longer-term provision of low-level support.

£6.00
ISBN 1-84598-015-8

Fighting for disadvantaged older people in the UK and overseas,

WE WILL:

**COMBAT POVERTY** wherever older people’s lives are blighted by lack of money, and cut the number of preventable deaths from hunger, cold and disease

**REDUCE ISOLATION** so that older people no longer feel confined to their own home, forgotten or cut off from society

**CHALLENGE NEGLECT** to ensure that older people do not suffer inadequate health and social care, or the threat of abuse

**DEFEAT AGEISM** to ensure that older people are not ignored or denied the dignity and equality that are theirs by right

**PREVENT FUTURE DEPRIVATION** by improving prospects for employment, health and well-being so that dependence in later life is reduced