

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

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### **Abstract**

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

**Keywords:** Intermediate care, integration, home care, care management

### **Introduction**

Currently, across England and Wales, both health and local authorities are engaged with the project of integrating health and social care services for older service users. This paper is based on group discussions and individual interviews carried out with care managers into the effects of integration in a recently merged Primary Care Trust (PCT) serving a shire county. Two broad sets of themes emerged. One related to the effects of changed organisational structures on working practices, organisational culture and professional identity. The other was concerned with the various (mainly positive) effects of integration for older service users. However, this paper focuses on an issue that affects a high proportion of older service users, concerning as it does, the critical interface of intermediate care and

mainstream social care. Despite progress in assessment and integrated working generally, it would appear that there are still certain issues that need to be ironed out before it could be said that the current system of service delivery is as person-centred and 'joined up' as envisaged in policy guidance. This paper examines recent messages from government in this area, and against this context, raises questions about how the aims of joining up services and achieving person-centredness, choice and improved quality of life could be more effectively achieved. The effect on those staff whose role is to implement the care management process at the interface between health and social care is also discussed.

### **The study: design and methodology**

This small-scale study used mixed qualitative methods – group discussion

followed by individual semi-structured interviews. The two group discussions comprised a total sample of sixteen workers from a Social Services older persons' team who were responsible for care management. The sampling was opportunistic in that an open invitation was made to any relevant members of the team who wanted to participate. Each group of eight was constituted to contain the same broad mix of staff in terms of seniority, experience and so on. The original focus of both the group discussions and the interviews was the 'impact of integration on social care services'. This was considered timely as the care managers were approximately one year into the new integrated way of working, no longer working for the local authority Social Services but for the local PCT. Against a background of considerable change, the care managers had welcomed the opportunity to talk about how the process was impacting on both them and the service users with whom they worked. The topic guide used to structure the group discussion included questions that asked the group to think generally about how their professional role and identity was changing/had changed throughout the integration process. Related to this were questions which asked about values, knowledge and skill sets.

Group discussions, or focus groups, can be a source of much rich data (Gomm & Davies, 2000). However, as Kvale (1996) states, it is a characteristic of group interviews that:

*The interaction among the interview subjects often leads to spontaneous and emotional statements about the topic being discussed (p.101).*

Kvale remarks that in such instances, the interviewer's control over the situation is reduced and that:

*..the price may be a relatively chaotic data collection (ibid).*

Although, the discussions were taped, the combination of the emotionally charged subject matter, the spontaneous interactions and the concomitant technical difficulties in recording the whole group clearly, led to some difficulties in data analysis. This was mainly because not everything that was said had been captured effectively. Nevertheless, what was captured showed a high degree of consistency between the two groups. Several responses highlighted that, in certain areas, staff were concerned about the effects of integration on service users. The issues and themes that emerged from the analysis were written up and fed back to the participants in a report as a check on accuracy. Although some have cautioned about such exercises as a form of validation (Silverman, 2000), on this occasion it proved useful because the analysis was approved overall by participants.

Because, on balance, the greater part of the group discussions focussed on the effects of change on the workers, it was decided that some of the problematic issues raised concerning the effects on service users should be explored in more depth by using individual semi-structured interviews. Both data sets were analysed using what could broadly be described as the constant comparative method (Silverman, 2000).

### **The policy background**

New Labour has consistently promoted flexible, person-centred services for older people. A key method in achieving this has been through the integration of health and social care services. In recent years both the *Health Act 1999* and the *Health and Social Care Act 2001* have paved the way for integrated care trusts.

At the same time, concern to avoid both unnecessary hospital admissions and so called ‘bed-blocking’ has led to the expansion of intermediate care services - first signalled as a major policy initiative in the NHS Plan. The *National Service Framework for Older People* (Department of Health, 2001) articulates both those ambitions. Additional measures to ensure timely discharge were set out in the Community Care (Delayed Discharge etc.) Act 2003. The effect of this Act was to remove the local authority’s ability to charge for community equipment and intermediate care services. This meant that these services would be free of charge to users. The aim was to help make access to services easier by removing a critical barrier to local authorities providing these services jointly with the NHS, whose services have always been free at the point of delivery.

A major part of the development of intermediate care by PCTs has been the creation of integrated domiciliary services in order to facilitate speedy hospital discharge and prevent unnecessary hospital admission. However, this service is time-limited (Department of Health, 2007). After this point, if older people’s personal care needs are ongoing, they are supposed to be met either by mainstream home care services or by direct payments. These days, the strong likelihood is that any directly provided services will be commissioned from an independent home care agency. As the Commission for Social Care Inspection has recently reported (CSCI, 2006b); as at March 2006, 80% of the 4,622 domiciliary care agencies in England were in the private or voluntary sectors.

### Measuring progress

From the various evaluations of the impact of reforms on older people’s

services which have emerged in recent years, a recurrent message has been that ‘consumers’ increasingly desire more individualised and personalised services. For example, in a recent document produced by the Commission for Social Care Inspection (CSCI) David Behan, former Chief Inspector of CSCI stated that:

*Meeting people’s expectations and delivering the policy ambition of the White Paper Our Health, Our Care, Our Say will mean developing a new way of commissioning. The challenge is to commission for personalised, bespoke care. Our evidence is that in many areas this does not yet exist (CSCI, 2006a: 4).*

Commissioning for ‘choice’ has now become a major preoccupation for policy makers and senior managers (See Clarke *et al.*, 2006, for a critical discussion of the emergence of the choice discourse). However, when intermediate care becomes the primary focus for evaluation, choice features noticeably less and other themes become foregrounded - ‘joined-upness’ and ‘bridging the gap’ being particularly prominent. In 2004, the Department of Health published *Better Health in Old Age* (Department of Health, 2004). The tone was mostly upbeat. About ‘joined-up services’, it states:

*We have promoted joined-up services by bridging the gap between hospital and home (2.2.1),*

continuing;

*On current trends we could see the end of delayed discharge as a significant issue for the health service within four years (2.2.3).*

Figures are given to show that the number of delayed discharges was down

and the number of households receiving intensive home care was up (Department of Health, 2004:14). These messages are reiterated in the more recent *A New Ambition for Old Age* (Department of Health, 2006). This document sees the challenge to provide care services that are not only joined-up, but also promote dignity, choice and are person-centred. Right at the end of this document, commissioning of services is briefly discussed:

*Members of the National Leadership Network have suggested ways in which commissioning might be developed for frail older people: strengthening multi-sectoral commissioning arrangements with greater use of pooled budgets, commissioning for integrated care networks (p.19).*

Therefore, 'integrated care networks' are clearly felt to be the way to achieve the necessary flexibility and person-centredness. Although, quite what this means on the ground is not explained.

One of the conclusions of the extensive report published by the Intermediate Care National Evaluation Team (Barton *et al.*, 2006) found that those involved in the management and delivery of intermediate care highlighted a range of perceived benefits associated with intermediate care. These were often linked to where care was delivered. For example, care delivered at home or in 'home-like' settings was contrasted favourably with traditional care (i.e. in hospitals). Also, some of those working in intermediate care reported cost effectiveness as another potential benefit. However, in particular, it was found that:

*For users, intermediate care was thought to represent patient-centredness, flexibility and*

*opportunities for independence (indeed, patient satisfaction levels captured via our questionnaire were relatively high). The opportunities associated with working in a multi-disciplinary/inter-disciplinary environment were identified as key benefits for staff in intermediate care teams (p.137).*

On a more negative note, the report's authors also concluded:

*Less positively, however, the qualitative research suggests that intermediate care is currently unable to fulfil its potential as a result of capacity problems and failings in 'whole-systems' working. Fragmentation and poor integration with other services remain features of current provision and continue to have an impact upon the ability of intermediate care to deliver patient-centred care and contribute towards health and social care systems as a whole (p.142).*

Interestingly, both sets of conclusions were reflected at a micro-level in the care managers' discussions: issues of fragmentation, poor-integration and the failings in 'whole-systems' working were readily apparent.

### **Issues identified**

It was clear that, on the ground, whilst integration had brought its advantages for older service users, there were some concerns reported that would repay further discussion. They can be located at the interface where intermediate care ends and where commissioned social care services begins. There are four different areas raised as problematic for service users; these are to do with unwanted change of carer, the (sometimes unfair) introduction of charging, the inappropriate use of respite

care due to capacity problems and the lack of appropriate commissioned home care services leading to integrated care services being unnecessarily tied up (a version of bed-blocking in the community).

Several care managers reported that the transition from one system of home care to another was often problematic. Older people have expressed concerns, for example, both about change of carer and the change to a system of charges. One senior worker said:

*We weren't giving out the right message. That is to say people were hearing that they could have 'of right' six weeks of free care. We are more careful now and say that it is up to six weeks and if care looks to be social in nature then they will be paying for it sooner. Also we prepare them better for the transition and warn them that there could be teething problems, although we try to make it seamless.*

It emerged that many discharges occurred without the older person being properly informed that the free, integrated home care that would get them home and out of hospital would need to change should domiciliary care still be needed after a few weeks. Whilst information available from the hospital discharge team did refer to the time-limited nature of the intermediate care service, it was felt that the full implications were either not made clear or, because of the pressure to effect the discharge, the fine grain of what would happen after the time-limited period was not fully explained. This was seemingly made more difficult because of unclear directions from the top. To quote another care manager:

*There is confusion about what people are charged for – initially we were*

*told the care was free for six weeks after discharge. Now we are told any of this care may be charged for.*

Therefore, the questions of whether and how to introduce charging emerged as a challenging issue. However, possibly an issue of even bigger significance for service users came with the change from the integrated team to a private care agency. As one care manager put it 'changing carer sometimes is a biggy'. It emerged that the issues here were mainly to do with familiarity, consistency, reliability and perceptions of competence. The change of care service could cause considerable disruption for the older person. Other studies (for example Piercy, 2000) have highlighted the importance of continuity and reliability for older people using domiciliary services. These issues were felt to be exacerbated if, for whatever reason, carer practices changed, timings changed and the older person concerned became unhappy about what they perceived as a lowering of service standards. A care manager described how:

*There are still major dissatisfactions and problems when care is passed over to the agencies – the service users usually advise it is not as good and do not want to start paying for care.*

More often than not, the perception was that the private agency care service did not match up to that from the integrated team. The reasons for this are diverse. However, a strength of the integrated team is the very fact that it is integrated, care staff are trained and are competent in both health and social care functions under professional supervision. Also, organisationally, they work closer to those making the care assessments. How successfully the private agency could take over the care was, to some extent,

dependent on the quality of the handover. In general, it was felt that the quality of care dipped at handover. The perception was that this was largely because private agencies struggle to maintain the same continuity of carer and the same level of training and supervision. Ironically, this is usually about the same time that charging is introduced. Several care managers reported that service users sometimes decide to dispense with care at this point, whether the need is still there or not. This caused the care managers some concern.

The research revealed that having to move from a free to a means-tested service created its own subset of issues which the care managers felt led to 'inequity'. Under *Fair Charging Guidelines* (Department of Health, 2001), service users cannot be charged until they have had a financial assessment. This means that when charging starts can vary significantly between service users. Those who have previously undergone a financial assessment, are charged from the moment they transfer to home care, whereas those new to the system can wait anything up to several weeks – even months - before they are charged. The fact that through the use of intermediate care, some social care is provided free has sharpened the debate both within the newly integrated team and with service users about whether social care should be free. It has also brought back into focus the related questions of what exactly 'personal care' is, when does health care become social care, for example over assisting with medication, bathing and so on. Alongside these questions, charging for care is a longstanding and controversial topic and the funding of home care is a complex political issue currently under debate (CSCI, 2006b; Joseph Rowntree Foundation, 2006). The huge costs

involved nationally mean that some element of charging will probably continue in some form. However, this research shows that this particular interface issue adds both to the confusion and the sense of injustice felt by many over what constitutes personal social care as opposed to personal nursing care. By initially providing domiciliary care free through an integrated team, but then charging for it when transferred to a care provider from the independent sector – even when the needs and the care tasks undertaken to meet those needs remain the same – helped create mixed messages about what precisely personal care is, and on what basis it is provided free of charge. Here, the older service users and the care managers would appear to be echoing concerns that have been articulated throughout the care system for some time (The Royal Commission on Long Term Care, 1999; Age Concern, 2001).

The problems with domiciliary care in England and Wales have been well documented (CSCI, 2006b). If the examples given by the care managers are experienced more widely, it would appear that the enhanced level of care provided by integrated intermediate care teams cannot always be matched by the various agencies operating in the independent sector. Examples were given where service users had simply refused to make the change – exercising their right to choice. In certain cases, grounds could be found for continuing with integrated care. A care manager stated that 'we always tend to stay involved if the service user is deemed to be palliative'. It is clear, then, that such negotiations are an important part of day-to-day practice. Both service users and care managers were sometimes able to construct and recategorise situations in ways that both resisted and challenged the current fragmented

system of care, in order to ensure continuity and person-centredness. However, this was not possible in the majority of cases. At this point, the rule-enforcing character of much of current care management practice became most apparent (Carey, 2003). Service users needed to be persuaded to make the transition from one care provider to another. This persuading, trouble-shooting, negotiating area of work, together with having to provide the, often lengthy, explanations of the charging system and the rules of eligibility to service users and their families, and then dealing with the inevitable reactions of anger, frustration and upset that this often caused, emerged as a large part of the hidden 'emotional labour' of the care management role (Hochschild, 1983; Aldridge, 1994; Clarke & Newman, 1997; Gorman, 2000).

This care manager's view was typical:

*There is confusion over when it is health care or social care. Health care is supposedly free. Management have been asked to clarify this, but the team remain unclear about what to advise people about costs – which can lead to angry service users.*

The tasks of explanation and service user pacification did not appear to be ones that were shared out evenly between all the various professionals in the integrated team. It fell to the social care staff. However, it was hoped that, as the integration process progressed, this would improve.

Another significant issue, reported by care managers, was that delays in finding suitable care from a private agency meant that integrated discharge teams found themselves tied up longer than anticipated given their time-limited role. As one care manager put it, 'this

blocks throughput'. This issue not only has its own impact on charging (i.e. delaying it), it also highlights the lack of joined-up care and whole-systems working at a critical point. Whilst a bed may have become 'unblocked', a blockage occurs in another part of the system. However, it attracts less attention because it is probably less politically sensitive. Nevertheless, the pressure to keep discharging people means that intermediate care services are being placed under huge strain and care managers clearly have to absorb much of this.

This bottleneck issue inevitably has a 'knock-on' effect elsewhere in the system. As a care manager put it:

*This is an equity issue as well,*

further explaining;

*There are occasions when the intermediate team cannot respond to an acute health problem and hospital is not the way to go and people end up in respite for which they pay for being unwell.*

Again, this issue seemed to occur fairly frequently and the outcome depended on the result of a process of pragmatic negotiation between professionals influenced by such factors as perceptions of risk, urgency and what other resources were available. The full cost of respite care was £351 per week which meant that such negotiations had considerable financial consequences for service users. Hence the frequently raised concern about 'inequity'.

## Discussion

The study finds that the integration of health and social care services, and, in particular, the expansion of intermediate care services, has highlighted the

fragmented and variable quality of mainstream home care services. Clarity, continuity and competence (particularly on matters relating to health) are important for older service users. Such concerns are borne out by CSCI's research into home care. For example, the Commission found how older people are:

*..often bewildered by the rules concerning what statutory agencies will and will not provide (2006b: 33),*

and that;

*One of the areas of most concern is the handling of medication, where there is a need to improve both procedures and training (2006b: 11).*

The study also highlights problems with the overall capacity in the system. Older people were often reported to be unhappy with the transition; the care was neither being operated on the basis of person-centredness nor choice. Care managers reported many examples of what they described as 'inequity' in the system, where inconsistency over charging played a major part.

Although, it would appear to go against the grain of policy since the community care reforms were introduced over a decade ago, arguably, the logic of integration and person-centredness suggests that large-scale use of a range of different private home care agencies might actually militate against person-centredness. Older people's needs on such occasions might be better met by the use of an expanded integrated home care service operated jointly by the PCT and the local authority rather than commissioning from private agencies. Certainly, the current system of, mainly privatised home care does not appear to be achieving the outcomes, such as reliability, flexibility and a sensitive and

professional approach, that older people regard as important (CSCI, 2006b).

From an economic point of view, if budgets in this area are limited, then a rationalisation of services could make financial as well as care sense. Brand (2007) for example argues:

*Local authorities are increasingly expected to deliver more for less, beyond the £6.45 billion savings demanded by the Gershon Review. The recent local government White Paper emphasised joint-working and pooled resources as a way of meeting these financial demands with shared services seen as a core efficiency tool. The potential savings in sharing back-room services alone are estimated at billions over the next decade. Furthermore, shared services should increase service resilience, cut lead times, join-up services and create simpler access for citizens, improving customer satisfaction.*

Such a move would help produce a consistent, professional approach with disruptions for service users minimised. Information sharing would improve by taking out unnecessary links in the chain of communication from different sets of carers. A movement in this direction might also address the problems identified by the Commission for Healthcare Audit and Inspection (2006) which, on the subject of staff recruitment and retention, found that NHS 'partner organisations':

*...are targeting the same small pool of staff and creating unhelpful competition in the employment market (p.20).*

Such a move, might also go some way to restoring confidence in 'public services' which successive governments

have marketised, privatised and 'hollowed out' (Marquand, 2004).

The future of social care is both challenging and complex. With the introduction of direct payments and, more recently, individualised budgets, service users now have the means to 'opt out' should they want to exercise their right to choice and make their own arrangements. In fact, with the likely shift from a small number of large local authority contracts to a multitude of small individual client contracts, the currently mal-functioning quasi-market for home care needs to be rationalised with steps taken to ensure that those choosing to stay with directly provided services have care that is not only flexible and person-centred but sufficiently secure and robust to cater for all eventualities – something which the independent sector and the current commissioning system have failed to do. Research has shown that schemes such as direct payments have the potential to bridge the 'health-social divide', but that more development is needed before this can be fully realised (Glendinning *et al.*, 2000, Leece & Bornat, 2006). Elsewhere, research has indicated that direct payments are possibly creating a 'two-tier' system where older service users, particularly when they are not greatly disabled, are tending to stick with directly provided services. Therefore, for the majority of older people who probably will not opt for direct payments, it is important that, on the grounds of equity, they too should be able to enjoy the benefits of integrated home care.

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