

# The organization, form and function of intermediate care services and systems in England: results from a national survey

Graham P. Martin, Graham J. Hewitt, Teresa A. Faulkner, Hilda Parker

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This paper reports the results of a postal survey of intermediate care co-ordinators (ICCs) on the organization and delivery of intermediate care services for older people in England, conducted between November 2003 and May 2004. Questionnaires, which covered a range of issues with a variety of quantitative, 'tick-box' and open-ended questions, were returned by 106 respondents, representing just over 35% of primary care trusts (PCTs). We discuss the role of ICCs, the integration of local systems of intermediate care provision, and the form, function and model of delivery of services described by respondents. Using descriptive and statistical analysis of the responses, we highlight in particular the relationship between provision of admission avoidance and supported discharge, the availability of 24-hour care, and the locations in which care is provided, and relate our findings to the emerging evidence base for intermediate care, guidance on implementation from central government, and debate in the literature. Whilst the expansion and integration of intermediate care appear to be continuing apace, much provision seems concentrated in supported discharge services rather than acute admission avoidance, and particularly in residential forms of post-acute intermediate care. Supported discharge services tend to be found in residential settings, while admission avoidance provision tends to be non-residential in nature. Twenty-four hour care in non-residential settings is not available in several responding PCTs. These findings raise questions about the relationship between the implementation of intermediate care and the evidence for and aims of the policy as part of NHS modernization, and the extent to which intermediate care represents a genuinely novel approach to the care and rehabilitation of older people.

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## Introduction

As part of its modernization of the National Health Service and its provision for older people set out in *The NHS Plan* (Department of Health, 2000a) and the *National Service Framework* for older people (Department of Health, 2001a), the British government has introduced a new range of services aimed at preventing unnecessary hospital admissions, facilitating earlier discharges and reducing premature admission to long-term care, collectively known as 'intermediate care'. Billed as a "bridge between community and hospital care" (Department of Health, 2000a: 42), intermediate care was to comprise services aimed at reducing acute hospital use and promoting community-based independence, primarily for older people, in response to the finding of the

National Beds Inquiry (Department of Health, 2000b) that older people accounted for around 20% of bed-days in acute care. Fanfare and considerable investment in intermediate care services followed, as did a good deal of criticism: detractors argued that intermediate care services working to prevent hospital admission would compromise older patients' access to acute services and diagnostic facilities, that older people might end up in 'warehouse wards' to free acute bed space, and that intermediate care investment would come at the expense of provision elsewhere in the system (Grimley Evans & Tallis, 2001; MacMahon, 2001; British Geriatrics Society, 2002; Pencheon, 2002).

A particularly acute criticism was that intermediate care was a poorly evidenced policy, and that as such government was rolling out its new scheme prematurely, with insufficient piloting, and with a naïve failure to recognize that a policy intervention that works in one local health and social care economy may not be so effective in another (Grimley Evans & Tallis, 2001; Ebrahim, 2001). Some evidence for the effectiveness of the kinds of interventions encompassed by intermediate care has been available for some time (e.g. Parker *et al.*, 2000; Steiner, 2001; Stevenson & Spencer, 2002); it is fair to say, though, that the breadth of service models covered by a catch-all term like intermediate care (Melis *et al.*, 2004), and the variation to be found in its implementation (Martin *et al.*, 2004), meant that there was a continuing need to evaluate intermediate care as put into practice in different areas of the country. The Department of Health and the Medical Research Council thus commissioned a £1.2 million programme of evaluation of intermediate care, funding three studies which have recently reported and are in the process of publishing their findings for the clinical, managerial and academic communities. This paper reports on one aspect of one of the three studies: a survey of intermediate care co-ordinators, which formed part of a national evaluation of the costs and outcomes of intermediate care carried out by Leicester and Birmingham Universities. The study also involved quantitative and qualitative data collection in five primary care trusts (PCTs) across England, and a systematic review of the literature on intermediate care published since 2000. These components of the evaluation will be reported elsewhere.

The aim of the survey component of the evaluation was to consider intermediate care as implemented across England, providing context for the in-depth case studies and giving a reasonable idea of how far intermediate care as it has been put into practice reflects the letter and spirit of policy guidance. In an interim report of survey findings, we have previously argued in these pages that intermediate care "*as it is being developed and delivered* is a constellation of complementary services rather than a straightforward, easily characterized model of care. ... [Intermediate care] is apparently being utilized to meet local needs of service users and gaps in provision" (Martin *et al.*, 2004: 153). We noted that this finding could be interpreted both positively and negatively: as a sign that local managers and clinicians were implementing intermediate care in a manner sensitive to prevailing local conditions; or as indicative of poor adherence to the models of intermediate care outlined by the central government in policy guidance (e.g. Department of Health, 2001b), for which some evidence, even if ambivalent, existed—such as hospital-at-home services (Shepperd & Iliffe, 2001). The findings we report here derive from a later national survey of intermediate care provision, employing a substantially revised method, in which we sought further to consider this question and others, in order to establish the nature and extent of intermediate care implementation across England, and to gather key managers' views on the benefits and challenges of putting intermediate care into practice. These managers—intermediate care co-ordinators (ICCs)—have been positioned in Department of Health documents as being at the forefront of efforts to ensure successful joint working between health and social care, with

"responsibility and accountability for promoting, and providing information about, intermediate care services; ensuring that intermediate care is integrated across primary care, community health services, social care, housing and the acute sector; and securing agreement on the scope of, and contributions to, pooled budgets."

(Department of Health, 2001b: 8)

At the time of implementation, then, these managers were at the pioneering end of joint working between the NHS and local authorities. In the context of the ongoing consolidation of intermediate care as a key layer in mainstream health and social care provision, the survey presents an image put forward by ICCs of the implementation of the policy and its organization 'on the ground', which we relate to Department of Health guidance, the emerging evidence base on the effectiveness of different forms of intermediate care, and the concerns of clinicians such as those mentioned above.

## Method

Building on our previous work (Martin *et al.*, 2004), in which representatives of individual services were interviewed, with a revised approach, this research involved a postal survey of ICCs—those individuals in PCTs or social services departments charged with managing and co-ordinating the area's intermediate care services (Department of Health, 2001b). In the absence of a national list of ICCs, these were identified through telephone contact with PCTs. To pilot the questionnaire, a random sample of 30 PCTs was contacted. Following this, telephone contact was made with the remaining 272 PCTs in England, minus those five involved in case study work as part of the evaluation, to attempt to identify the ICC responsible for the area of each. Despite the fact that the Department of Health (2001b) mandated the NHS and local councils with social services responsibilities to jointly appoint ICCs in each health authority area (PCTs inheriting this responsibility from health authorities following the 2001 reorganization of the NHS), persistent telephone inquiry resulted in the identification of only 232 out of 297 ICCs or other postholders with responsibility for intermediate care (25/30 pilot sites, 207/267 remaining sites)—a significant and arguably troubling finding in itself.

The pilot survey was carried out in November 2003. Questionnaires were sent to the remaining sites in February 2004, with a follow-up reminder letter and copy of the questionnaire sent to all sites who had not responded in March.

In brief, the survey covered the following main areas through a mixture of tick-box, closed and free-text questions:

- background, funding and role of ICC;
- factors helping and hindering intermediate care development locally;
- description and capacity of service system; and
- local organization of intermediate care, and joint working between health and social services in this.

In this paper we report findings related to the first, third and fourth topics above. Data from the questionnaire were entered into a spreadsheet to enable aggregation of the results and cross-tabulation between different sections of the survey, including some basic statistical analyses, using Excel 2000 and SPSS 14, to explore the association between responses to different questions.

## Results

By May 2004, those responsible for some 106 PCT areas had responded: responses to the pilot survey (7/25) were included alongside responses from the subsequent survey (99/207), as no significant changes were made to the questionnaire or other aspects of the method following the pilot. This represented an overall response rate of 46% of those 232 PCTs for which we had been able to identify contacts, and 36% of our sample frame of 297 PCTs. Comparing responding to non-responding PCTs (table 1) showed no significant differences between the two in terms of star rating, rate of delayed transfers of care from acute hospitals, or population size.

### *Role and remit of the intermediate care co-ordinator*

As noted above, the Department of Health (2001b) has emphasised the importance of the role of

	Responding PCTs		Non-responding PCTs		Test statistic	P value
	mean	SD	Mean	SD		
Star rating <sup>a</sup>	1.93	0.69	1.80	0.72	Mann-Whitney U, Z = -1.394	0.163
Rate of delayed transfer of care <sup>a</sup>	3.84%	2.52	3.43%	2.23	Mann-Whitney U, Z = -0.326	0.744
Population size ('000) <sup>b</sup>	161	57	161	61	two-tailed t <sub>(295)</sub> = 0.076	0.940

Table 1: Differences between primary care trusts (PCTs) responding to survey and non-responding PCTs (including those for which intermediate care co-ordinators could not be identified, but excluding five case-study PCTs not included in survey) in terms of Healthcare Commission star rating, rate of delayed transfer of care (percentage of patients whose discharge or other transfer of care from acute hospital was delayed), and population size.

<sup>a</sup> Source: Healthcare Commission PCT performance ratings 2003-04, <http://ratings2004.healthcarecommission.org.uk/>

<sup>b</sup> Source: DEFRA PCT classifications 2005, [http://statistics.defra.gov.uk/esg/rural\\_resd/rural\\_definition.asp](http://statistics.defra.gov.uk/esg/rural_resd/rural_definition.asp)

ICCs in its policy implementation documents on intermediate care, stressing that this was to be a joint post pertaining to health and social care with a strategic and operational role at the pioneering end of co-operative working between the NHS and local authorities. The data collected on the background and role of ICCs in the survey are thus of some interest, as is the fact, already noted, that in some 65 English PCTs the ICCs could not be identified.

Most (59/106, 56%) of the ICCs who responded were funded by the health service; 38 (36%) were jointly funded by health and social services, and only seven (7%) were funded by a local authority alone (two responses missing). It should be noted that this may partly be due to our route of contact, via PCTs. However, it also seems to reflect the primarily health service-oriented slant of intermediate care, as a policy which has its roots in capacity shortages in the acute sector, although social services departments are now assessed on their performance with regard to delayed transfers of care from hospital, emergency admissions of older people and admissions to long-term care.

As might be expected given the age of the policy, most (57/106, 54%) respondents stated that they had been in post for one to three years, with a further eight (8%) having been appointed in the last year. More than a third, however, had been in post for four years or more, suggesting that they had been involved in developing intermediate care services of sorts well before the policy was formally introduced by the Department of Health.

Half (51/106, 48%) the respondents described their roles as both strategic and operational, with 28 (26%) describing their role as strategic only and 16 (15%) as operational only. ICCs who were jointly funded by both health and social services were significantly more likely to describe their role as strategic ( $P=0.039$ ; see table 2), suggesting that in these systems the ICC was more likely to take the strategic role intended by the Department of Health (2001b). As such, one might expect that these ICCs would be in a better position to further the strategic integration of intermediate care, as envisaged by the Department of Health (2002), with intermediate care moving from isolated services, each with their own referral criteria and governance arrangements, to a system of integrated provision across a locality, incorporating the contribution of health, social services and housing. However, there was no discernable relationship between the source of funding of the ICC and the profile of intermediate care provision in the locality reported (whether made up of separate intermediate care 'schemes', an integrated intermediate care 'system', or moving from the former to the latter). Nor was there any significant relationship between profile of intermediate care provision and whether or not ICCs described their roles as strategic. In recent intermediate care policy documents, the Department of Health (2002: 8) has indicated to managers the importance of "vision, drive and leadership" in bringing about service

(a)	ICC role		Test statistic	P value
	Strategic	Non-strategic		
Health-funded ICC	41 (69%)	18 (31%)	$\chi^2_{(2)}=6.58$	<b>0.039</b>
Social services-funded ICC	4 (57%)	3 (43%)		
Jointly funded ICC	34 (89%)	4 (11%)		
(b)	Independent sector involvement			
	Yes	No		
Health-funded ICC	32 (54%)	27 (46%)	$\chi^2_{(1)}=3.07$	0.080
Social services- or jointly funded ICC	32 (71%)	13 (29%)		

Table 2: Relationships between (a) funder of intermediate care co-ordinator (ICC) and whether ICC describes her/his role as strategic, and (b) funder of ICC and independent sector involvement in intermediate care.

reorganization and integration, emphasising the importance of

“the ability to see beyond existing organizational boundaries and historical patterns of service delivery and to understand the changes that need to be made in order to redesign services more appropriately. Given the range of obstacles facing those breaking new ground and challenging orthodoxies to develop new services, drive and determination are needed in no small measure to make the vision a reality.”

Clearly, though, any such driving role depends crucially on the many other relevant factors in a complex health and social care system, and the findings of this survey do not present a direct link between the position and remit of the ICC and the integration of intermediate care provision.

#### *Organization of services and systems*

Overall 57 (54%) respondents stated that intermediate care in their localities was in the process of moving from separate services to a single integrated intermediate care system, with just under a third (34/106, 32%) indicating that the system was fully integrated and 14 (13%) functioning as separate services (one response missing). In reporting details on individual services, however, only 11% presented their provision as a single integrated intermediate care system, with others giving details of a number of discrete services: this suggests, perhaps, that there was some disjuncture between ‘strategic’ integration (in terms of management, accountability and so on) and operational integration (in terms of allocation of staff, referral criteria and the experience of the service user), though of course even an integrated service is likely to incorporate a number of different models of service provision, offering, for example, both care at home and care in residential settings.

An array of separate services, then, appeared to be the norm for the systems included in our survey, which incorporated anything between one and nine services, with a median of four services per system (interquartile range two to five) and a mean of 3.74 (standard deviation = 2.13) (see also figure 1). Descriptive data were provided by respondents, then, on a total of 396 services, from single integrated models to small individuated services. From these descriptions, it seems likely that not all of the latter would meet the definition of intermediate care as set out by the Department of Health (2001b), with some representing peripheral services which would make a contribution to the provision of intermediate care (such as community night-nursing services), and others seemingly part of mainstream health or social care (such as domiciliary care services). Whilst the contribution of such services to intermediate care may undoubtedly be significant (cf. Martin *et al.*, 2004), it is questionable whether their activity should be counted as a part of intermediate care capacity (though we do include them in the service-level analysis in this paper). This is an issue to which we return in our discussion below.

A third (136/396, 34%) of services were started before 2001, prior to the introduction of intermediate care as an official policy directive, with a quarter (99/396, 25%) starting in 2001 or 2002, and just under a quarter (87/396, 22%) in 2003 or 2004 (data missing for 74 services).

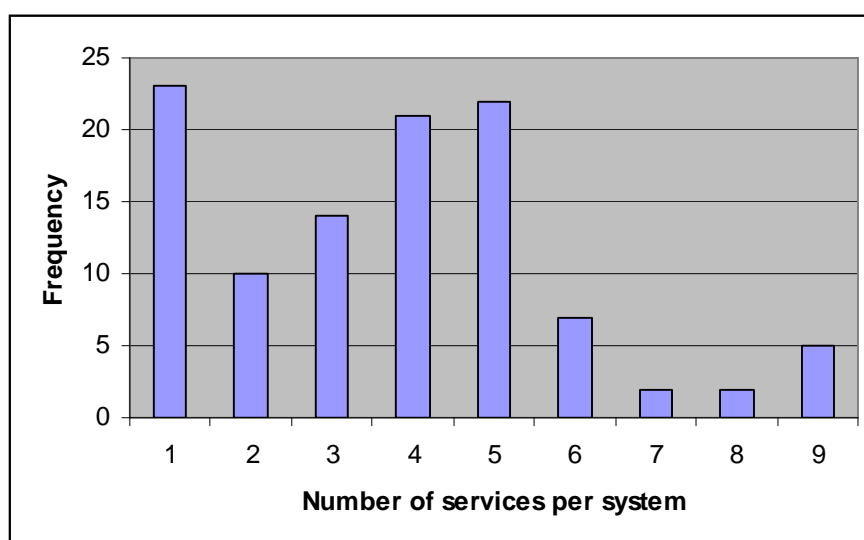


Figure 1: Number of services per locality reported by intermediate care co-ordinators.

That much provision predated the Department of Health's (2001b) guidance on the implementation of intermediate care is not surprising, and the question of whether the expansion of intermediate care represents genuinely 'new' capacity or the rebadging of existing services remains an issue. The launch of further services in the last few years, though, suggests that new development is continuing apace.

Respondents were asked to indicate which agency served as the primary host of their services: health was given as the host of 164 (41%) and social services of 53 (13%) services, with 167 (42%) hosted jointly by health and social services. Only five services (1%) were reported as hosted by the independent sector (data missing for seven services). As with the funding of the ICC, it would appear that health remains the dominant provider in intermediate care. In the wider context of the explicit positioning of intermediate care as a project in which collaboration between health and social care was expected and could be enhanced, though, the substantial number of jointly hosted services may be an indication of joint working spreading and increasing. Another expectation of the Department of Health (2001b, 2002), that the independent sector be involved in provision, would not from these data seem to have been well received, with only five services in the 106 systems commissioned from the private or voluntary sectors. On the other hand, another question, which asked more generally about whether the independent sector was involved in intermediate care provision, elicited an affirmative response from 65 out of 106 ICCs (61%). (The apparent incongruence between these two findings might reflect a sourcing of, for example, staff from the independent sector without the wholesale purchase of services from independent-sector providers.) Cross-tabulation with the source of funding of ICCs (table 2) seemed to suggest that localities with solely health-funded ICCs are less likely to involve the independent sector, which may reflect the more recent promotion of private and voluntary sector involvement in health than in social care, but this apparent relationship was not statistically significant at the 95% level ( $P=0.080$ ).

#### *Intermediate care form and function*

Information provided on the make-up of provision in the respondents' localities included data on the service models through which intermediate care was provided in practice, including the location of provision, numbers of beds and non-residential places, availability of 24-hour care, and function (acute admission avoidance or supported early discharge). The setting of provision is one obviously important dimension of intermediate care, given the overarching aim of the policy to provide 'care closer to home', the evidence for the effectiveness of rehabilitation in the home environment (Wade, 2003), and increasing doubts over the cost-effectiveness of inpatient

<i>Location of care</i>	<i>Number of services</i>
<i>Non-residential</i>	
Service user's home	151 (38%)
Day hospital or day centre	15 (4%)
<i>Residential and non-residential</i>	
More than one location, both residential and non-residential	68 (17%)
<i>Residential</i>	
Residential or nursing home, and sheltered housing	60 (15%)
Community hospital	39 (10%)
Dedicated intermediate care facility	26 (7%)
Acute hospital	14 (4%)
No response	23 (6%)
<b>Total</b>	<b>396</b>

Table 3: Location in which intermediate care provided

intermediate care (Walsh *et al.*, 2005). Table 3 presents the data on the location in which care was provided in the 396 services referred to by respondents. Of note from this is that a total of 139 (35%) services provided intermediate care in residential settings, with 166 (42%) in non-residential environments (including day hospitals and day centres as well as patients' own homes) and 68 (17%) in both.

The availability, or not, of 24-hour care is another important component of intermediate care provision: it could be argued that if a service is to provide a realistic alternative to hospitalization which can cater for relatively dependent service users, then the availability of night-time cover is important. Of 219 services providing care in non-residential settings (including 68 providing care in both residential and non-residential settings, but excluding 15 day facilities which by definition cannot provide overnight care), only two fifths (84/219, 38%) were reported as able to offer 24-hour care. The lack of 24-hour care in many of these services suggests that many of the patients using intermediate care are of relatively low dependency, rather than high-dependency acute or post-acute patients being cared for outside an acute setting. If we consider the availability of 24-hour care on the level of the intermediate care *system* rather than by individual service, 82 (77%) of the PCTs for which questionnaires were returned had at least one service (residential or non-residential) which provided 24-hour care, and 16 had none (eight ICCs did not provide this information). That some 15% of PCTs surveyed provided no 24-hour cover at all is somewhat concerning, and arguably suggests an entire intermediate care set-up oriented mainly towards older people with low-level and 'social' needs.

Respondents were asked to estimate the balance of referrals to each service in their area between the two principal functions of intermediate care, acute admission avoidance and supported discharge. Figure 2 gives a breakdown of responses to this. If these estimates about proportion of referrals for each function of intermediate care are combined with estimates about the number of users seen by each service, then we can infer that 83% of referrals are for supported discharge, and only 17% for admission avoidance. The proportion of data missing on both these questions was quite high, and each represents a 'best guess' on the part of the ICC rather than careful audit of referrals, but the suggestion is certainly that intermediate care is predominantly a service for the support of discharges from hospital rather than the prevention of admissions in the first place.

There was a statistically significant relationship between service function and setting of care (residential or non-residential) (see table 4). Services in non-residential settings were more likely to serve an admission avoidance function (arbitrarily defined as 80% or greater of referrals being for admission avoidance), while those in residential environments were more likely to provide supported discharge (80% or more of referrals being for supported discharge) ( $P=0.048$ ). If this relationship is considered in a slightly different way, by relating numbers of *individual beds and non-residential places*, instead of setting of service as a whole, this finding is sustained (table 5): 76% of

	AA 80%+	Mixed	SD 80%+	Test statistic	P value
Non-residential (home / day facility)	28 (26%)	55 (51%)	24 (22%)	$\chi^2_{(2)}=6.09$	<b>0.048</b>
Residential (residential/nursing home, sheltered housing, community hospital, dedicated unit, acute hospital)	16 (16%)	46 (47%)	36 (37%)		

Table 4: Relationship between setting of care (residential/non-residential) and predominant service function (admission avoidance (AA) / supported discharge (SD) / mixed) according to figures estimated by intermediate care co-ordinator.

predominantly admission avoidance provision reported took the form of non-residential places, while 53% of predominantly supported discharge was provided through residential beds, though the large numbers in mixed admission avoidance and supported discharge provision should be noted as these cloud the picture somewhat. In some ways, this corresponds with our finding above on the availability of 24-hour care. Arguably, it is slightly perverse that the more intense provision to be found in residential settings seems to be aimed primarily at those coming out of hospital rather than at those at risk of admission. If admission avoidance is to include high-dependency patients with a need for 24-hour care, then the support offered by a residential environment is a viable option; conversely, it seems that supported discharge patients are mainly being catered for with a lengthier stay in intermediate care beds, when evidence increasingly suggests that this can be costly (Griffiths *et al.*, 2001; Walsh *et al.*, 2005), at least when provided in hospitals, and that post-acute rehabilitation is most effective in the patient's home environment (Wade, 2003).

## Discussion

The response rate to the survey was disappointing, though well preceded for this kind of postal-survey research (Asch *et al.*, 1997), but the responding PCTs did not appear to be significantly different from non-responding PCTs in terms of PCT rating, rate of delayed transfers of care from acute hospitals and population size (table 1). Responses were received from ICCs in every strategic health authority and from rural and urban areas. The survey produced a sizeable enough dataset to provide interesting insights into the implementation of intermediate care nationally, some reinforced by statistically significant associations. It is possible that those responding to the survey sought to portray local provision in a favourable light, although it was made clear that anonymity of responses would be respected and that this was independent research rather than central monitoring, and certainly this did not seem apparent from the data. The range of responses, in terms of hosting arrangements, size and organization of intermediate care systems, and geographical spread of localities, also suggests that our research has captured a good deal of the qualitative diversity in intermediate care set-ups.

The survey presented some findings which reflect interestingly on the place of intermediate care at the centre of efforts to enhance joint working between health and social services. Whilst joint funding is hardly the be-all and end-all of effective collaboration between agencies, the fact that many services and ICCs were hosted or funded by both health and social services suggests that the policy is one in which both sides of the 'Berlin Wall' are engaged. Jointly funded ICCs were more likely to describe their roles as strategic ones, but we could not identify a relationship between ICC funding source and the degree of integration of intermediate care. We would not expect to find such a direct correlation, and this serves to highlight the fact that the scope and depth of collaborative working and integration between PCTs and social services is dependent on much wider factors than pooled financial arrangements.



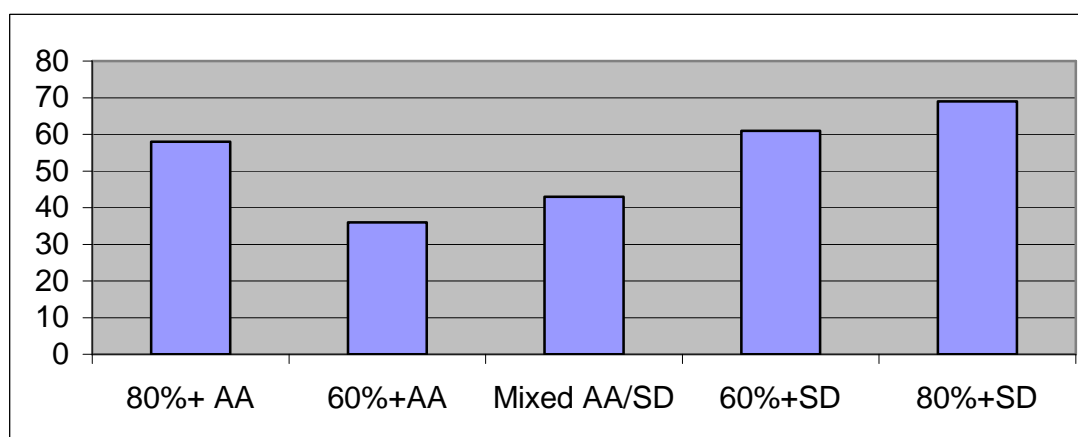


Figure 2: Numbers of services by proportion of referrals for acute admission avoidance (AA) or supported discharge (SD) as estimated by intermediate care co-ordinator.

As we found in our previous survey work, the diversity of service provision in intermediate care is striking, with variations within and between systems in terms of form, function and location of services. It is apparent that intermediate care development has been highly sensitive to local context: old services predating the introduction of the policy have come under the intermediate care banner, and new services have been developed which vary immensely in remit and scope, and which are often united only by their label. The diversity has been hailed by the Department of Health (2002: 5), but also recognized as limiting the maturing of intermediate care into an established, mainstream service:

“In many ways this diversity has been a strength, giving intermediate care the ability to adapt to a wide range of circumstances and to the needs of individuals, but the proliferation of schemes has also led to confusion and fragmentation. This in turn has led to inequality of provision and access, duplication of effort, reduced cost effectiveness and loss of impact.”

That our survey suggests that 86 percent of localities are either moving towards, or have achieved (at least strategically), an integrated intermediate care system may be of some comfort to policymakers in this regard. However, there are other, possibly more intractable, issues which arise from this degree of diversity, and which remain in the integrated systems. With such an array of styles of service delivery counted as intermediate care, both the degree to which localities are adhering to well evidenced models of provision, and the meaningfulness of aggregate statistics on capacity and throughput compiled by the Department of Health from local returns, must be called into question. The difficulty which some ICCs seem to have had in providing fairly basic descriptive data on individual services for our survey, indicated for example by the fact that information on function and location of care was provided for only 273 out of the 396 services identified by respondents (see table 4), makes these questions all the more vexing. When the Secretary of State for Health reports that around 12,800 more intermediate care places were available in 2002/2003 than in 1999/2000, far exceeding a target of 1700 by 2003/2004 (*Hansard* 6 October 2003 Column 1335W), one cannot help but question the basis of such an assertion: despite the comparatively tight definition of intermediate care put forward by the Department of Health (2001b), ICCs in our survey included various services peripheral to—and some which to us seemed quite distinct from—intermediate care, and these same ICCs are responsible for reporting throughput and capacity figures to the Department of Health. (Equally, this should serve as a reminder of the limitations of the findings reported here!) To some extent, this is an inevitable tension between central accountability and local autonomy: central government has provided further implementation guidance to ICCs (e.g. Department of Health, 2002), including

	AA 80%+	Mixed	SD 80%+
Non-residential places ( <i>services</i> )	466 (22)	3994 (75)	716 (28)
Residential beds ( <i>services</i> )	144 (13)	1244 (57)	807 (36)

Table 5: Numbers of non-residential places and residential beds reported in services offering predominantly admission avoidance (AA), mixed provision and predominantly supported discharge (SD), according to figures estimated by intermediate care co-ordinator.<sup>a</sup>

<sup>a</sup>Some services offer places and beds: these are included in both rows if numbers of places and beds are both known. Information was not provided on function, location of provision and/or numbers of beds and places for 208 services.

'best practice' recommendations but leaving discretion in the hands of local managers, and Grimley Evans and Tallis' (2001) assertion that policy needs to be implemented *and evaluated* locally is well founded. Nevertheless, we would argue that some clarity and uniformity in the reporting of intermediate care is essential for the meaningful audit of capacity and throughput, as well as for the practice of evidence-based policy implementation.

Data from the survey suggest that the majority of intermediate care supports discharge rather than preventing acute admission. We also found a lack of 24-hour care in many services, and even in some entire systems, which suggests that a good deal of intermediate care provision may be aimed at comparatively low-dependency older people rather than those in need of the overnight provision afforded by acute hospitals or alternatives. These findings might provide some reassurance to geriatricians who have expressed concern that intermediate care may represent the diversion of older people in need of acute care away from hospitals and from skilled diagnosis (e.g. Grimley Evans and Tallis, 2001; Bulger, 2002). On the other hand, they may suggest that the extent to which intermediate care is truly contributing to alleviating pressure on acute beds is questionable, a finding which also arose from our case-study work. Equally, the apparent predominance of supported discharge services in intermediate care, which accounted for in the region of 83% of capacity reported by respondents, may provide comfort for clinicians concerned about the clinical safety of admission avoidance services that lack the involvement of geriatricians. But it also suggests that one particular potential benefit of intermediate care to the health system (and to older people), the prevention of unnecessary admissions to acute care, is not being realized to the same extent as the support of older people post-discharge. This raises questions over the extent to which intermediate care may contribute to current policy efforts to reduce emergency admissions and support older people with long-term conditions in the community.

This configuration of intermediate care, with so much provision, particularly post-acute, taking place in residential environments, may arise from the incorporation of existing provision, such as some community hospital beds, as part of intermediate care, and may also have resulted from the sizeable capital investments in intermediate care made through central government grants to localities (amounting to some £66 million from 2002). Furthermore, our finding that post-acute intermediate care was significantly more likely to be provided in residential settings, and admission avoidance intermediate care in non-residential settings, suggests that there may have been some prescience in Ebrahim's (2001: 337) prediction that supported early discharge would mean "shunting sick people to another institution." It may also reflect less desirable practice if these residential settings mean that the therapeutic advantage of rehabilitation in the home environment is lost (Wade, 2003), especially given current pressures to discharge promptly as embodied in such policies as reimbursement for delayed discharge.

## Conclusion

It is important to stress that the findings we present here are based on the incomplete responses of a fairly low proportion of ICCs in England. Nevertheless, they do provide some picture of the nature and spread of intermediate care 'on the ground', a picture that has largely been lacking

while the debate among clinicians, academics and policymakers about the flaws and merits of intermediate care has been taking place. Though this part of our work does not shed any light on the effectiveness of intermediate care, it does provide an idea of how the policy has been put into practice, in particular with regard to the diversity of implementation and the apparent development of some functions and forms of provision to a far greater extent than others. In the context of an increasing evidence base for the costs and effectiveness of the different types of intermediate care being provided by the programme of evaluation and other research, this work provides important knowledge of the manner of intermediate care implementation nationally and its relationship with policy, debate and evidence.

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