Priorities for the development of older people's services in South Korea: lessons from the United Kingdom

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Kyeung Mi Oh

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Contents

Abstract

This thesis aims to inform the older people's service agenda for South Korea by drawing lessons from recent appraisals of British health care and social care services for older people, the rationale for recent reforms, and an evaluation of a specific service innovation (the Barnsly Rapid Response Service). The research has three main elements: (1) an appraisal of unmet service needs among older people and key services delivery problems in South Korea (2) an evaluation of the new intermediate care service in Barnsley, and (3) the implications of the findings for the UK and for South Korea.

The Barnsley RRS provides a valuable holistic assessment service for a particular group of older people with chronic health problems and disabilities, and in certain respects responded to unmet needs. Its brief episodes of care in some cases also achieved a reorganisation of the patient's care and treatment, to the benefit of the patient and achieving reduced staff involvement and patient contact. However, the impact of RRS was limited by its qualified acceptance by both GPs and hospitals. If intermediate care schemes are to make a difference, they need to be given greater 'powers' in relation to GPs and hospital physicians.

The social circumstances of older people in South Korea have changed radically in recent decades and the need has increased for formal care services for those who are frail and have no informal carers. However, the dominant influence of physicians on health service development underlies the low current priority for 'care' as opposed to 'cure', as also for improving the management of chronic conditions and rehabilitation. The experience of the UK strongly suggests that South Korea should develop domiciliary health and social care services alongside institutional care to meet older people's various care needs. Furthermore, a comprehensive system of treatment and care for under-served patients with chronic health problems should be developed. South Korea should consider establishing innovative care services like the UK 'intermediate care' schemes to overcome the fragmented services and to encourage collaborative delivery. To achieve these innovations, education and training in multidisciplinary team working are required. Another priority should be to improve the quality of care by adopting minimum standards of care and stronger systems of regulation and inspection. To overcome the difficulties of innovative service implementation, feasibility planning and careful preparation are essential.

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Publications

Extracts and data from this thesis have been published in the following paper and abstract:

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Chapter 1

Introduction and outline of the thesis

This chapter introduces this doctoral thesis on innovative care services for older people and the lessons for South Korea of the British experience. It discusses the background to the thesis, and its aims, objectives and structure.

1.1 Background to thesis

Everywhere around the world a substantial change in the age composition of the human population is occurring. The enormous successes and achievements in health and social development have enabled more people than ever before to survive to old age. In particular, it is observed that the speed of the 'age structure transition' of the countries that have recently begun the transition, such as South Korea, has been much faster than in European countries where the transitions began. For example, in France the share of the population aged 65 years or more years reached seven per cent of the population in 1865. The same point was attained in the United Kingdom in 1930 but in South Korea only in 2000. The doubling of the share took 115 years in France and 45 years in the United Kingdom (UK), but is expected to take just 22 years in South Korea (UNO, 1991; Chung, 1998). The age structure change has resulted from substantial decreases in both fertility and mortality.

Modernisation and industrialisation have been also accompanied by a wholesale change in occupations, values, life-styles and the spread of secondary and higher education. This has brought a revolution in aspirations and expectations and, more specifically, changes in the willingness and ways in which adult children support or care for their parents when old and frail. Until lately and for many generations all over east Asia, the acceptance and practice of filial piety has conditioned relationships between older parents and adult children (Knodel *et al.*, 1992; Martin, 1989). In fact, even if the origins of its recent forms are not known, 'respect and care for parents and older people' has long been a norm and obligation of adult children in the Korean culture (Sung, 1995). While the family has been primarily responsible for the material support and welfare of older people, public welfare has been subordinate to macroeconomic growth goals. Recent decades have seen, however, weakening family support for frail older people, and this has greatly increased the need for formal services for older people. Consequently, one of the most challenging areas for health and social policy in South Korea is to develop a national strategy for the care of frail older people.

On the other hand, the United Kingdom confronted the problem of a combination of an increasing older population and rising care and treatment expectations earlier than Korea, and consequently also experienced before the problems of developing service provision for older people. Indeed, the UK pioneered many community-based and residential services for the group. Today the United Kingdom has a comparatively well developed range of care services for older people, while Korea is in the early stages of their development. The overall premise of this thesis is that it will be instructive for the development of care services for older Koreans to examine the strengths and weaknesses of British care services for older people and, more specifically, to understand both the reasons for the current service development priorities, and the problems and pitfalls of service innovation.

1.2 Aims and objectives of the thesis

The aim of the thesis are to inform the older people's services development agenda for the Republic of Korea through an appraisal of health care and social care services for older people in the United Kingdom, and an original evaluation study of a service innovation.

The objectives of this research are:

1. To evaluate in the light of population ageing, the needs of older Koreans for health and social services.
2. To appraise the principal strengths and weaknesses of health and social care services for frail older people in the United Kingdom.
3. To understand current service development priorities in the UK.
4. To evaluate a selected service innovation for older people in Barnsley, South Yorkshire, and to assess whether the scheme is meeting its objectives, providing an effective and worthwhile alternative to inpatient hospital care, and is satisfactory to service users.
5. To elaborate and communicate the lessons for care service development in South Korea.

1.3 Thesis structure

This thesis has four sections and 13 chapters. The first chapter covers the background to the thesis, elaborates the aims, describes the main source of information, and outlines the thesis structure.

The first section reviews the demographic and social changes in South Korea that have changed the conditions and service needs of older people. It has three chapters (2 to 3). Chapter 2 examines population ageing in South Korea and the changed social circumstances of older Koreans. Chapter 3 summarises the history of care services for older Koreans and provides a summary description of existing health and social services and residential and nursing-home care. It then assesses old people's unmet service needs in South Korea.

The second section (Chapters 4 to 5) reviews care services for older people in the UK. Chapter 4 summarises the development of health and social care services for older people in the last 20 years and explores their strengths and weaknesses. Chapter 5 concentrates on the rationale for the wholesale introduction of innovative intermediate care services for older people in the last few years. One such service, the Barnsley Rapid Response Service (RRS), hospital avoidance scheme, was chosen for the original evaluation, which forms the primary empirical research core of this thesis.

This service is fully described in Section 3 of six chapters (Chapters 6 to 11). Chapter 6 describes the background and the design of the evaluation study. Chapter 7 presents the patients' characteristics, referral pathways and the service outcomes as revealed by the operational data of the Barnsley District General Hospital (BDGH) and the RRS. Chapter 8 is a report of the experience of the new service in the first year as revealed through field observation. Chapters 9 and 10 present the patients' and staff's evaluations of the care scheme. Each chapter is therefore based on a separate study, and each includes the study design, conduct of the study, strategies for data analysis, the results and a discussion of the findings and study limitations. Chapter 11 synthesises the findings from the empirical evaluation.

The final section comprises two chapters. Chapter 12 focuses on the implications of the empirical findings for UK policy and practice development and further research. Chapter 13 develops the lessons of the RRS evaluation and of my contextual studies for older people's services in my own country.

Section I

Older people's health and social care in South Korea

Chapter 2

Demographic and socio-economic changes[1]

As in other east Asian countries, in South Korea there is a strong cultural tradition and repeated affirmation of the values and practices of 'filial piety'. Among its many expressions, it has led successive governments to assert that the family is and should be responsible for the material support and care of older people, and therefore to claim that it is not necessary to develop social security old age income systems or formal care services for frail older people. The enthusiastic pursuit of a capitalist model of economic development, with strong influences from the United States and Japan, has encouraged even South Korea's responsible governments (a number since the 1950s have been corrupt) to argue that its primary responsibility is to create a legal and fiscal environment that is conducive to business, which translates into low personal and corporate taxation and a minimal welfare state. The clear contradictions between socio-economic ideologies and the changing circumstances of family members of both working and old age has led to a widespread critical debate about the ideology of filial piety, as well as a strong empirical research focus on trans-generational mutuality, reciprocity and living arrangements. This chapter explores the adaptability of inter-generational relations and seeks to identify the formal care service needs of older people. It begins by describing recent demographic and socio-economic change in South Korea, and then considers the implications for the circumstances of older Koreans in terms of support and care.

2.1 Demographic and socio-economic background

In 1998 South Korea had a population of 46.4 million at a density of 467 people per square kilometre which, excluding city-states, is one of the highest in the world: the population density is 12 per cent higher than that of The Netherlands (OECD, 2000). Over the last 30 years, South Korea has had one of the most rapidly growing economies in the world. The Gross National Product per capita in 1961 was US $82, among the lowest, but it had increased to US $10,543 by 1996, in which year the country joined the Organisation for Economic Co-operation and Development (OECD), a clear sign of its 'developed' country status (Oh, 1999: 225). The country has recovered from the

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[1] Parts of this chapter (in an earlier version) were published in Oh and Warnes (2001).

1997 financial crisis with output increasing nearly 11 per cent in 1999 and nine per cent in 2000 (OECD, 2001: 8).

As explained in Chapter 1, industrialisation and modernisation have been accompanied by substantial decreases in both fertility and mortality, which have caused rapid increases in the relative number of older people. The population share aged 65 and more years in 1966 was just 3.3 per cent, but by 2000 it had reached 7.1 per cent, and it is expected to be around 13.1 per cent in 2020. The speed of the 'age structure transition' has been much faster than in European countries or Japan.

Table 2.1 Duration of the age structure transition in five countries

Country	Year in which the share of the population aged 65 years or more attained:		Interval (years)
	7%	14%	
South Korea[1]	2000	2022*	22
Japan	1970	1994	24
United Kingdom	1930	1975	45
France	1865	1980	115
Sweden	1890	1975	85

Source: Before 1940: United Nations Organisation (UNO) (1956) *The Aging of Population and its Economic and Social Implications.* Population Studies 26. UNO; New York. After 1940: UNO (1991) *World Population Prospects 1990.* Population Studies 120. UNO; New York. 1. Chung (1998), International trends and the socio-economic meaning of population ageing. *Health and Social Welfare Policy Forum.* 26. Seoul, Korea Institute for Health and Social Affairs (KIHASA).* Official projection.

The absolute number of people aged 65 years or more has recently increased swiftly, from about 1.45 million in 1980 to 3.0 million in 2000, as a result of the previously high birth rates and improved survival. Another doubling in the next 20 years is projected but if the current low level of fertility continues, the fast growth will draw to an end from the middle of century. It has not however been only the increasing number of older people that has produced a growing need to improve the welfare state in terms of pensions, health care and long-term care. More significant have been simultaneous changes in the nation's occupational structure, household arrangements, educational system and normative values which, among other things, have changed the social circumstances of older people. The process of modernisation has embraced more specific transitions affiliated with urbanisation and industrialisation. As recently as 1955, only one quarter of the population lived in urban areas. By the late 1970s a majority did so and, by 2000, around four-in-five will (Keyfitz and Flieger, 1990: 226).

The country's welfare system has the following 'pillars': national health insurance (from 1989), a national pension scheme (1988) that will begin paying regular pensions in 2008, public assistance (educational and medical benefits covering the poorest 4.5 percent of the population, from 1993), industrial accident assurance (from 1962) and unemployment insurance (from 1995). There have been many attempts to explicate the country's distinctive income support policies and programmes, with a clear shift over the last decade from 'cultural' to 'statist' explanations (Kwon, 1997; 1999).

Another repeated interest has been to demonstrate the similarities and dissimilarities of South Korea's welfare programme to those of both the other ASEAN 'economic tigers' and the two most similar European countries: Austria and Germany. In the terminology of Esping-Anderson (1990), the latter exemplify 'conservative welfare regimes' that highlight insurance principles, support for employed men and their families, and cash transfers, but do not improve social services or pursue income redistribution. Holliday (2000: 707) has argued that the distinctive feature of the east Asian 'productivist' welfare model is that it constantly subordinates social policy to macroeconomic and economic growth goals. The early phases of public welfare development in all countries emphasise the alleviation of poverty and educational and health policies targeted on children, in part to raise the quality of the labour force. Later, however, modernisation, accompanied by decreased fertility, smaller households and increased longevity progressively change the balance of needs. The creation of such a 'threshold of need' for formal care services for frail older people in South Korea and the early responses are the focus of this section.

2.2 Changed social circumstances of older people

Since the 1960s the life-styles and ambitions of the South Korean people have considerably changed, with significant consequences for older people's position in society and for the sources of material and instrumental support. Until lately and for many generations all over east Asia, the acceptance and practice of filial piety greatly affected relationships between older parents and adult children (Knodel *et al.*, 1992; Martin, 1989). In fact, 'respect and care for parents and older people' has long been a norm and obligation of adult children in the Korean culture (Sung, 1995). The conventional expression has been for older parents to live with the eldest son, his wife and children in three-generational households, and for all to share in the work of a collective economic unit, usually an agricultural small holding or, in towns, a domestic manufactory or shop. In successfully functioning and harmonious households, all family members cooperatively created and received its material and emotional support, for all contributed to the domestic, semi-subsistence and considerably non-cash economy, which was established around the senior couple on condition that they were healthy, active and capable.

While the rationale for these arrangements originated in agricultural production, if an older parent became physically or mentally frail, support was supplemented with care. The responsibility to remain in the parents' household, and to care for them when old, was not however distributed equally to all children. The customary anticipation was that the eldest son would live with the parents, while other sons and daughters had less responsibility. Nevertheless, filial piety affected all children, for the complement of the instrumental responsibility was that the eldest son and his wife were given more privileges than the siblings, especially with regard to education and the inheritance of property. The family is essentially responsible for the welfare of the older people by providing financial and practical assistance.

In today's Korea, however, family values and customs have weakened and changed. As an example, the belief that the eldest son has to take the primary responsibility to provide financial and practical assistance for his older parents is fading. Successive surveys have found that, in 1979, 30.6 per cent of South Koreans aged 14 years and over believed that the eldest son should take the main responsibility, but only 19.6 per cent did so in 1996 (Ministry of Finance, 1992; 1996). The reasons for the decrease include the spread of higher education, its impacts on material and occupational ambitions, and increased women's participation in employment and non-family social activities (Ingersoll-Dayton and Saengtienchai, 1999; Sung, 1998; Chi, 1988; Palmore and Maeda, 1985; Silberman, 1962; Lang, 1946). Married women's participation in employment increased from 37 per cent in 1970 to 50 per cent in 1997 (Choi, 2001).

The traditional multi-generational and extended family household production unit provided a context for reciprocal support and inter-generational support and care, it was underpinned by mutuality, and it strengthened and legitimated filial piety. On the other hand, in a modern or post-modern economy the commodification of labour prevails and domestic forms of production are scarce. The pursuit of employment and production become competitive rather than symbiotic with the support and care for frail and ill household members (including frail parents) (Oh and Warnes, 2001). It leads young people to migrate to the cities, where millions experience insecure employment, low income and in the rudimentary dwellings of 'substandard settlements' (Ha, 2001;

Ha and Lee, 2001). The Korean economy was bailed out by the International Monetary Fund (IMF) in 1997. During the 1997 to 1999 economic crisis, the levels of poverty and dismissal in these settlements increased considerably, and private income transfers to older parents fell distinctly (Kwon-S, 2001). Urbanisation has strengthened this, for neither shanty towns nor high-rise city apartments are as suitable for three generational households as rural houses (Choi, 1999).

The decrease in multi-generational living arrangements in South Korea has been remarkably swift (Table 2.2). For instance, the proportion of older people aged 65 years or more who lived with their children fell from 77 per cent in 1984 to 50 per cent in 1994 (Kim and Rhee, 1999:95; Kim, 1998). Simultaneously, the proportion of older people who live alone has swiftly increased, from 4.3 per cent in 1981, to 7.7 per cent in 1988 (Korean Gallup, 1990), and to 19.4 per cent in 1997 (Table 2.3). Won and Lee (1999) have found an inverse association between income or educational level and the likelihood of an older parent living with married children. Over the last several decades, the succession of birth cohorts has resulted in an increasing proportion of the middle-aged having received secondary and higher education. The implication is that the residential independence of elderly Koreans will spread.

Table 2.2 Family household types: South Korea 1960-1995 (%)

Year	1960	1970	1980	1990	1995
1 generation	5.3	6.8	8.8	12.0	15.3
2 generation	65.4	70.0	73.1	74.1	73.3
3 or more generations	29.3	23.2	18.1	14.0	11.4

Note: The tabulated households exclude one-person or non-kin households, 14.8% of all households in 1995. *Sources*: For 1960-1990: Korea National Statistical Office (1997) *Changes in Population Structure and Their Implications for Social Policies.* KNSO, Seoul. For 1995: Kwon, T.H., Kim, T.H. and Choi, C.H. (1995) *Population and Family in Korea.* Ilsin Publishing Co., Seoul.

Table 2.3 Living arrangements of older people: South Korea, 1997 (percentages)

Co-resident with children[1]	Living alone	Living with spouse only	Other[2]	Total
56.2	19.4	22.9	1.5	100.0

Note: The sample size was 1,888 people aged 65 years and over. 1. Own or child's home. 2. Co-resident with a relative or friend or in a residential care or sheltered home. *Source*: Korea Institute for Health and Social Affairs (KIHASA) (1997). *Research on the State of the National Birth Rate and Family Health.* KIHASA, Seoul.

Personal and political expressions of modernisation in South Korea have included intensified demands for human rights, freedom and justice. Women have demanded and been granted more opportunities for higher education and they have pursued equal rights with men. Thus, women's status has much improved, and their participation in the economy and social institutions beyond the household has significantly increased. Traditionally, house-keeping was considered as defining women's role, and the wives of eldest sons were expected to take care of frail older parents. Korean education and socialisation traditionally highlighted humanitarian and communal values, but now the educational curricula and value systems have been westernized. Meanwhile, individual achievement and 'actualisation' is widely accepted as the most appropriate determining belief for individual behaviour and social life (Oh and Warnes, 2001). In contemporary society, women with higher educational qualifications are rarely expected to 'sacrifice' themselves to care for older parents. One explicit result is that in the contemporary cohort of young adults, the majority of women do not want to marry men who are the eldest sons.

A decline in the population's willingness to take care of frail older parents is inferred in many countries from the decrease in multi-generational co-residence: a prevalent over-interpretation. Actual changes in the emotional and instrumental relationships between older parents and their adult children will of course have transformed in intricate ways, but it is simplistic to believe that all weaken the emotional or instrumental interactions between parents and children (Choi, 2000). Just as successive cohorts of children have received more education and had the prospect of different, less physically-laborious and more intellectually-demanding occupations, older parents' life experiences and expectations of their children have changed. As in all affluent countries, growing wealth, increased car ownership and spreading telecommunications have increased the capability of the members of one generation both to keep in close touch with and to provide convenient and useful support for another.

Clear expressions of new forms of mutuality and reciprocal support have been demonstrated from the studies of the child-sponsored migration of South Korean older people to the United States, particularly Los Angeles (Lubben, 1999; Lubben and Lee, 2001). To make fast material progress, both husband and wife in many recently arrived Korean migrant couples want to work full-time, but professional child-care is very expensive. Generally also, the parents in South Korea are poor and many feel deeply the absence of their child and grandchildren. As the resolution, the child finances the parents' migration to Los Angeles, which in Lubben's sample of 223 occurred at an mean age of 62 years, after which they provide child day-care. The exceptional outcome among more than a few multi-generational migrant households is that the parents see their sons less frequently than those who, although in Los Angeles, live in separate households.

There is increasing research evidence of 'carer-strain' in South Korea (Chung, 1998; Youn *et al.*, 1999), and growing media coverage of the physical abuse and occasional abandonment of frail older parents (Table 2.4). It is not explicit whether the increasing trends are the events or their report: it may be, for instance, that in the past the consensual norm of filial piety in intentional or unconscious ways restrained such reports.

Regardless of whether the prevalence of psychological and physical neglect and abuse has increased, the changed household arrangements and increasing expectation that a sick older parent should receive high quality of care has escalated the need and demand for formal domiciliary and residential health and social services. If this statement is accurate, the task facing the South Korean government is twofold. It is to plan and manage the swift installation of the health and welfare services that are more and more needed by an affluent, westernised population; and to respond to the distinct disadvantages that are pervasive in the present cohort of older people and which are expected to continue for several decades.

Table 2.4 Newspaper reports of elderly abuse in South Korea, (Jan to Jun 1997)

20 Jan	An elderly woman with dementia was trapped in a garage by her child and then died.
24 Feb	An old person with dementia committed suicide by throwing herself from the top floor of the house.
6 Mar	A old person with dementia was pushed into a wall by her son and died.
6 Mar	Several violent fights took place among five sons about whose duty it was to care for their elderly mother with dementia.
6 March	A woman with dementia went to the toilet and had a fall. Her annoyed son assaulted her and she died from her injuries.
13 Mar	A son who was depressed by his father with dementia committed suicide with his father.
22 Mar	An old person with dementia was assaulted and verbally abused.
23 Mar	An elderly woman was left in a house fire and died.
18 Apr	A husband who was depressed by his wife's dementia committed suicide with her.
24 Apr	An older person with dementia who had been missing for seven months was found dead in a valley.
1 May	A son who was angered by a conflict between his elderly mother and his wife abandoned the mother by a riverside.
16 May	An older person with dementia who had been missing for several months was found in the mountains
16 May	An older person with dementia was abandoned in a shelter.
10 June	Three children refused to take care of their older mother with dementia. A son, annoyed by the conflict between his wife and her mother, put the mother in a tent on a river bank and gave her a few cooking instruments. She was found by a policeman.

Source: *Joonang-Ilbo* (Seoul daily newspaper) 1997.

Chapter 3

Services for older people[2]

As described earlier, population ageing and interacting economic, social and attitudinal transformations have changed the social circumstances and care needs of older people in South Korea. As a consequence of the changes, the country faces a problem of how best to support ever-longer living older people. Although there have been a number of initiatives, their capacity does not correspond to the increasing needs of frail older people and their informal caregivers. This chapter aims to identify the unmet care needs of older people by establishing which few services are currently available. This chapter begins by exploring the history of social and health welfare policy for older people, and then considers health care expectations and provisions. The current health and social care, and residential and nursing home care for older people are then presented and finally unmet formal care service needs of older people are discussed.

3.1 The history of social and health welfare policy for older people

The Korean Ageing Policy, the government's approach to services and policies for the older people, has a short history. For instance, in the 1960s, poverty was the most important social problem, and the problems of population ageing hardly considered. Ageing issues and particularly the difficulties of older people: income maintenance, disease, role loss and premature retirement began to be of concern in the 1970s. The government's approach to services and policies for older people was at first unco-ordinated. Since the *Older Persons Welfare Act 1981*, the primary policy goals have been income maintenance and health care services for older people and their family caregivers. The Act created tax incentives, awards and honorifics to encourage families to provide care and shelter for older relatives. In fact, the legislation affirms and supports the traditional family role in the support and care of older people ('family support first and Government welfare next') (Choi *et al.*, 2001). The amended *Older Person Welfare Act 1989* did little to develop social services (in-home or community care) or institutional care. From the middle of the 1980s, private-sector institutional care for the middle and higher social classes began to grow.

From the early 1990s, the development of long-term care became a significant

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[2] Parts of this chapter (in an earlier version) were published in Oh and Warnes (2001).

area of government concern. Its definition was extended to home, community, and institutional based health and social care. In 1991, marking the United Nations International Year of Older Persons, a Long-Term Plan was established and the government office for elderly welfare and health. By a further amendment of the *Older Persons Welfare Act 1997*, a greater diversity of institutions for older people were created: nursing homes; residential care-homes and elderly welfare centres (for social services: including day care, respite care, rehabilitation, bathing facilities and meals). The predominant form of elderly services development in the 1990s has been institutional care. For example, the number of institutions increased more than five times during the last ten years although is still lower than in other developed countries.

In January 1999, the Government published a development agenda called 'Mid to Long-term Development Directions for Elderly Health and Welfare in Preparation of the Ageing Society of the 21st Century'. Its main goal is to improve the independence, participation, care self-fulfillment, and dignity of older people through strengthening income security, securing healthy life, providing welfare services and promoting an 'active elderly' culture. In contrast to the immense aims, it did not clarify the steps for achieving the plan. It initially focussed on the care of mentally disabled older people and the increase in the home / community care services. To overcome the weakness of the agenda of 1999, a *Planning Committee for Long-Term Care for Older People* was established in 2000. Currently, a system of social insurance for long-term medical treatment is beginning to be considered to ease the growing difficulties of frail older people and their families.

3.2 Health care expectations and provision

In Korea's pre-modern society, health care was the responsibility of the individual and the family, not of society or the state. It was customary that, besides self-care, the family, the clan, villagers and the community cared for the sick. Those attitudes have been largely abandoned, and health care has become a responsibility of the state through the introduction of national health insurance and large investments in medical facilities and training. The number of hospitals and clinics trebled between 1975 and 1998, and the number of licensed doctors increased from 16,800 to 65,431. By 2000 total government expenditure on health and social welfare had reached 4,257 trillion Won (US$ 3.94 billion), 5.2 per cent of its total spending (www.korea.net, see Health and Medical Services). As early as 1977, the South Korean government began to develop universal access to health care with three principles: graduated compulsory coverage; contributions based on individual income; and the level of benefit to be independent of individual contributions (Son, 1998a). It took 12 years, through successive measures that cascaded from large urban employers to own-account agriculturalists, to accomplish universal coverage (Table 3.1). The scheme is divided into *Medical Aid* for people whose incomes fall below a poverty standard (about 4.3 per cent of the population in 1995), and *Medical Insurance* for the general population, with alternative schemes for the employed and self-employed. Coverage is not open-ended but has lately been extended. The maximum covered period of hospitalisation was 270 days in 1997, but has subsequently been increased incrementally to one year in 2000 (MOHW, 2001).

Table 3.1 Key steps in the development of universal health insurance

1977	Insurance compulsory in firms with more than 500 employees
1977	Government programme for low-income individuals (Medical Aid)
1979	Insurance compulsory for government employees and private-school teachers
1979	Insurance compulsory in firms with more than 300 employees
1981	Insurance compulsory in firms with more than 100 employees
1981	Three pilot schemes for the self-employed
1982	Three additional pilot schemes for the self-employed
1982	Insurance compulsory in firms with more than 16 employees
1988	Insurance compulsory for the rural self-employed
1988	Insurance compulsory in firms with more than 5 employees
1989	Insurance compulsory for the urban self-employed

Source: South Korea: Ministry of Health and Welfare (1996) *Yearbook of Health and Welfare Statistics.*

Table 3.2 Expenditure on health care in South Korea, 1985-96

Year	Total Billion KRW	Services for older people	
		Billion KRW	Per cent of total
1985	583	28	4.7
1990	2,220	239	10.8
1996	7,424	976	13.1

Source: South Korea Medical Care Insurance Corporation, *Medical Care Insurance Statistics: Annual Reports* 1985, 1990, 1996. MCIC: Seoul.

Note: In August 2001, the exchange rate was one USA dollar to 1280 South Korean Won (KRW). Billion = 1,000,000,000

Since the introduction of the national health care insurance, the utilisation of health care has hugely increased, by 12.7 times or 26 per cent a year during 1985-96, while the patients' payments to the costs have fallen. There has been even faster increases of expenditure on services to older people, *i.e.* by 35.5 times or 38 per cent each year (Table 3.2). Increased utilisation has been promoted by the spread of the mass media and their rising coverage of health issues, therapies and the quality of medical treatment. The have encouraged an ever-greater comprehension of disease and growing demands for new treatments and care services. As in all countries, the understanding of health factors is positively associated with the level of education, and so there is a lag among older people. As nevertheless the proportion of older people educated beyond high school (14.9% in 2000) is anticipated to reach 27.0% in 2010 and 44.4% in 2020, expectations among the age group for good health and functioning are likely to grow rapidly (Chung and Oh, 2000).

3.3 Health and social services

Health care in South Korea is provided mainly by independent medical practitioners and private sector organisations which run more than 91% of all hospitals and clinics and employ 89% of all physicians (Ministry of Health and Welfare, 2000a). The private hospitals and clinics are largely in urban areas and operate in a competitive market. Their activity is greatly underwritten by the national health insurance scheme and the government's finance of medical, paramedical and nursing education and training. While the private-market approach has increased the volume and quality of services, the level and growth rate of government health care expenditure has nonetheless been problematic for successive South Korean administrations. In fact, the health insurance fund went into deficit in 1996 and has since increased. The financial stability of the health insurance scheme depends on the behaviour of both heath care providers and consumers (Kown, 2001). For instance, from 1994 to 1998, the medical expenditure on older people grew by 176%, but the older people grew by only 16% (NHIC, 1999). Part of the reason for the sharp increase of health-care expenditure has been the promotion of private-sector health care (Kwon, 2001). Another contributory factor has been that the government 'has lately taken some bold [reforming] steps ... such as separating the prescription and sale of drugs and unifying the diverse health insurance systems into a nationwide scheme' (OECD, 2001: 15).

Table 3.3 Types of health care facilities

Primary Care	Secondary hospitals	Tertiary hospitals	·Special hospitals
Health centre	District:100-699 beds	Regional: 700+ beds	Mental health
Health sub-centres	Local: 30-99 beds		Rehabilitation centres
Individual practitioner clinics			Cancer clinics
Special clinics			Communicable disease clinics

Source: MOHW (2000a) *The Status of Health Care*

Table 3.3 presents the current structure of health care services, which has four sectors: primary, secondary and tertiary care, and special hospitals. Among the various primary care facilities, the health centres, sub-centres and individual primary care posts are funded and administered by the government and provide health care for the poorest and most needy. The national referral system allows patients to visit primary care facilities in their local area at will, from which when appropriate they are referred to specialists and hospitals. Since the universal national health insurance scheme was initiated in 1989, the demands on the primary care sector have quickly increased.

Home health-care was established in 1991 and is managed from the primary care centres. In 1993 the *Association of Korean Registered Nurses* started to provide home health-care from four hospitals. Furthermore, the government provided a model hospital-based home health service from four tertiary hospitals during 1994-96, and it experimented with similar schemes from 45 secondary hospitals during 1997-99. The hospital-based home health services concentrate on the nursing care of patients who are discharged at an early stage from acute hospitals, while the home health services managed from primary care centres concentrate on health promotion and disease prevention among low income groups.

The development of health and welfare services in Korea has had a long history of conflict between traditional herbalists and 'western' biomedical physicians (Son, 1998b) but otherwise repeats the experience of many other countries (Le Fanu, 1999). One is an uneasy tension between universal and targeted provision. The former has been driven by the rising expectations and increasing affluence of the population and the mounting political 'leverage' of health issues; the latter by moral, humanitarian and collective concerns for the welfare of the most deprived. Welfare programmes targeted on the most disadvantaged and lowest income groups began in 1984 with means-tested forms of income support, collectively termed 'Livelihood Protection'. These extended into 'nutritional supplement' programmes which were managed from the primary care centres and laid the underpinning for the introduction in 1983 of the 'Elderly Health Examination Service'. This offers free health examinations, health education, early diagnosis and the management of multiple chronic diseases among older people. Echoing the initial lack of enthusiasm among British general medical practitioners for the annual 75+ years health check, the implementation of the scheme made a slow start. The quality of this service has subsequently much improved, but due to budget limitations access remains restricted to those who are eligible for Livelihood Protection. Services are also very concentrated in urban areas. Yoo *et al.* (1998) demonstrated that older people in rural areas had considerably more health problems than city dwellers even after all other variables were controlled, and they attributed the differential to the scarcity of health care services outside the cities.

Home care (or personal social services) was initiated in 1987 and expanded greatly from 1995 (MOHW, 2000b). It supports those who have problems with the activities of daily living (ADLs) and instrumental ADLs through physical or psychological disabilities. Older people who are registered in the Livelihood Protection scheme are eligible for free home care, while those recognised as on low incomes are charged only direct-cost fees. Other older people can only access fee-for-service home care. As the majority of home care clients are eligible for Livelihood Protection, it is obvious that most of those who are ineligible but in need do not wish to pay for home care services or find that the service does not provide value-for-money.

Day care centres for old people provide bathing facilities, rehabilitation, social activities, and meals to those who are mentally or physically disabled and whose family are not available to care for them during the day. The number has been growing and reached 37 in 1999 (MOHW, 2000b) and 97 in 2000 (Choi *et al.*, 2001). Like other services for older people, access to this service is limited to a small minority of poor older people. Respite care has also been developed to relieve family carers, for instance, by enabling them to take a vacation from the long-term care of a disabled older people. This service provides assistance with ADLs, rehabilitation, and meals. The duration is restricted to 45 days, and not more than 3 months care is provided to an individual during a year. The providing centres increased from 15 in 1997 to 36 in 2000, but remain too few and access is again restricted to poor older people.

3.4 Residential and nursing home care

As in other countries, one of the most demanding areas for health policy in South Korea is to develop a national strategy for the long-term care of frail older people. Constant adherence to the principle that the family supports and cares for older parents has obstructed the development of residential care. Dedicated care services for older frail people are categorized into the 'elderly health examination service', dementia services, and long-term care. The key types are residential homes, nursing homes, specialised hospitals for old people, and municipal and provincial dementia hospitals. As in northern European countries, residential homes are for older people who suffer from disabling or multiple disorders and need assistance with functional limitations, while nursing homes are predominantly for those who are suffering from dementia, paralysis or severe functional limitations and therefore need nursing care. There is scarce evidence on how well this distinction is maintained, *i.e.* whether there are good assessment and admission procedures or (as in Britain 20 years ago) substantial mis-matching of needs with placements. Specialised hospitals are for people who have serious (and often multiple) chronic diseases and need long-term medical treatment and comparatively intensive nursing care. Access to free institutional care is restricted to the poorest older people.

There are too few residential places for physically and mentally-impaired old people, and a considerable proportion of the available places are luxurious and serve the rich. The underlying need is a function of the strong relationships after around 70 years of age between increasing age and, firstly, the incidence and prevalence of seriously disabling physical and mental disorders, and secondly, spousal bereavement or widowhood. Inevitably, as people age after their sixties, an increasing percentage have high care needs but are without spouses or surviving and available children, siblings or others who can provide care.

Several responses to the needs of frail and sick older people are found in all societies, including neglect and abandonment, vigorous but informal responses and practical help from extended kin or from the local community, private or public sector formal domiciliary care, and residential institutions funded by the users, charities or the state. All western countries have created a substantial infrastructure of supported living and nursing home accommodation. Among those aged 65 years and over in South Korea, however, only 0.3% are resident in institutions (compared to 6.0% in Japan, 5.7% in the United States and 5.1% in the United Kingdom) (OECD, 1998). One regrettable result, is that the abandonment of very sick older people is still a common occurrence in South Korea (Oh and Warnes 2001). Presently, to decrease the aggregate cost of 'elderly care' and to enhance the quality of the users' lives, most western countries give priority to the development of home based-services rather than residential services. The experience of western countries cautions against the dangers of developing excessive residential care, but at this time there is undoubtedly a need to increase provision.

By a revision of the *Elderly Welfare Act* in 1993, the establishment of independent homes in a competitive market for residential care was approved to promote private-sector investment. Diverse individuals and companies expressed interest in establishing residential homes, but the legislation prohibits the sale of a care home and this has hindered investment. Only non-profit organisations, such as religious organisations and charities, and a large commercial company that seeks to improve its image, are anticipated to become involved in the expansion of provision. To promote their involvement, during 1993-2000 the government made US $8.7 million *per annum* available as loan finance to the private sector.

Until lately, most Koreans accepted a responsibility to look after a demented parent fatalistically and as an expression of their familial responsibility, and were unlikely to send the parent to a mental hospital – an eventuality which since 1989 has been covered by the national health insurance (Sung, 1996). Partially for this reason, mental health services for older people have not developed strongly. Lately, nonetheless, the population's comprehension of dementia and its attitude to the care of an older person with dementia have altered, and the need for services has significantly increased. The adoption of both western models of health care and of a rationalist view of mental illnesses have raised expectations that the afflicted patients will be treated and cared for by professional medicine. Care services for demented people were first initiated in 1997 with the aim of enhancing the quality of patients' lives. Public health centres manage this service, which involves diagnosis, registration, care assessment and care planning. Besides, counsellors provide information and advice to informal care-givers, and advocate for their support. The public health centres additionally provide home health services to the registered patients.

The Ministry of Health and Welfare (2000b) has lately published standards and regulations for residential and nursing homes but most are unambitious. As one instance, nursing homes and residential homes are obliged to employ one nurse per 50 residents (MOHW, 2000b), very low in comparison to the standards of other countries[3]. Furthermore, nursing standards are not specified at all. As found in other countries, regular inspection of the homes is necessary to secure the quality of older people' lives, but this has not yet been set up. The imperative tasks for the government and the country are consequently to increase the numbers of residential care places, to set higher standards of care and to establish effective quality assurance through regulation and inspection.

While long-term care services for older people in South Korea are less developed than in western countries they are now a government priority, and both community nursing and residential care services are being developed (Shin, 1998). Although domiciliary services are available to patients of all ages, the main patient group is older people, including those with terminal conditions such as cancer, those recuperating from surgery, and those with functional disabilities. The majority of South Koreans are largely unaware of the capacities of the community-based services, and the nurse-provided home health services do not meet the public's expectations: the public still favour hospital-based physician services to which they have been accustomed. Because of the limitations in the home health services' capability to meet old people's complex health care needs, and because the system makes charges and the quality of its services are not uniformly high, only a small number of older people are supported by the home health services (Oh and Warnes, 2001).

3.5. Conclusion: unmet care needs of older people

The changed social circumstances of older people in terms of support and care for older people have not been produced simply by population ageing but also by interacting economic, social and attitudinal transformations. The negative results are usually

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[3] UK: Care Homes for Older People: National Minimum Standards – Staffing (DoH, 2002)
27.1 Staffing numbers and skill mix of qualified/unqualified staff are appropriate to the assessed needs of the service users, the size, layout and purpose of the home, at all times...27.3 The ratios of care staff to service users must be determined according to the assessed needs of residents, and a system operated for calculating staff numbers required, in accordance with guidance recommended by the Department of Health...28.1 A minimum ratio of 50% trained members of care staff (NVQ level 2 or equivalent) is achieved by 2005, excluding the registered manager and/or care manager, and in care homes providing nursing, excluding those members of the care staff who are registered nurses (p.34). In Japan it is required that eight nurses and 20 nurse aides be present per 100 beds (Maeda, 1989).

described as impacting on older people, but it would be more accurate to say that they have specifically affected a defined birth group or, in individual families, the particular generations whose expectations for their living situation and support in old age have been denied and disappointed. For them, the 'silent promise' has been broken: later generations and cohorts will not acquire the same expectations and will have more substantial assets and welfare entitlements. The severest impacts are on a 'transitional generation' of older people, most of whom have attained or will attain old age during the two or three decades each side of the millennium, whose eldest (or any) sons have broken the sequence expected by the inter-generational understanding. The similar changes in western Europe were spread over up to five generations and, reflecting the longer phasing of occupational and educational change, were slower. In South Korea, however, the transformation has been concentrated into one or two generations of the nation's older people.

The development of health and welfare services in South Korea has to date been deeply influenced by the structure and divisions among the welfare professions and medical specialties. The leading influence of physicians has contributed to a low priority for 'care' rather than 'cure', and for the rehabilitation and the management of chronic conditions. The dominance is even greater than in southern European countries and may derive from the century-long conflict between traditional and western bio-medicine. Meanwhile, the influence of other health professions such as nurses, physiotherapists, and occupational therapists remains weak. Even in the development of care services for disabled older people, the focus has been on the expansion of acute medical services, while community care and rehabilitation, long-term care services, and personal social services have been scarcely developed. Nor yet have there been considerable initiatives to enhance the co-ordination and joint working of different services.

Although care services for frail and sick older people have a relatively short history in South Korea compared to western countries, they have quickly developed since the 1960s but still have many limitations. First of all, most of the care services are available only to those minorities of older people who are either eligible for 'Livelihood Protection' and have very low incomes or are very rich. The needs of the majority of frail older population are not being met. As Kwon (1997: 481) says of the underlying logic of the country's social policy, 'the vulnerable population has been left out rather than protected, and the workings of the system are divisive rather than an enhancement of the solidarity of society'. As well as the quantitative shortfalls, there are concerns about the quality of many older people's services. A priority now is to establish and implement minimum standards of care and stronger systems of regulation and inspection.

Other limitations of the existing health and social care system include widespread public ignorance and misunderstanding about care services. Most care services depend heavily on volunteer staff. But there are strengths in South Korea's care services for older people: firstly, although the private hospital and clinic functions are unregulated (Shin, 1998), the highly competitive market in which they operate has had a positive effect on the quantity and quality of acute medical services (Yang, 1996). Secondly, while from the 1960s to the early 1990s the main concern of successive governments was economic development, which produced barriers to the development of care services for older people, the current administration has shown a concern for and commitment to health and welfare issues including those particular to older people. While public spending and fiscal concerns may have been paramount, the government is now actively developing a long-term care policy which should result in increased and improved residential and nursing home care provision. As even the OECD acknowledges even while it keenly advises the government 'to limit the impact of ageing on expenditures', 'the traditional pattern of elderly care will require to be supplemented by a larger government role' (OECD, 2001: 15).

Section II

Appraisal of services for older people in UK

Chapter 4

British care services for older people in the last 20 years

A strong effort by government to improve health and social care services for older people has been evident earlier in the United Kingdom than in any East Asian Country. The provision of care services is neither static nor inevitable but has been progressively elaborated, partly by learning from various trials and mistakes, and partly in reaction to many economic, social and political pressures. As shown from the history of the development of care services for older people in the UK, the consistent aim of all previous innovations in care services has been to provide improved and excellent care services. Unfortunately, however, the aim has not always achieved.

Although previous innovations have not completely met the needs of older people, their experience is still of value for other countries where care services for older people are at an early developmental stage. Lessons can be learnt from the strengths and weaknesses of British innovations in care services for older people. In other words, the British experience on developing care services for older people has relevance for South Korea, a country where the demands from older people for care services have been rapidly increasing but the development of these services is at an early stage. It may be possible for South Korea to avoid mistakes that Britain made, and to adopt and adapt the successful forms.

This chapter reviews the major strengths and weaknesses in the innovative health and social care services that have been either dedicated to or made significant contributions to older people's care for the last 20 years. It does not include significant dimensions of welfare provision for older people, such as pensions, income support and housing, or the substantial contributions of informal carers. It begins with a brief account of the changing profiles of older people, to understand the background of the development of care services for older people. Then key innovations in care services of the previous Conservative governments will be considered, such as the internal market, the divesting of long-term care from acute hospitals, the promotion of primary care in the NHS, and the promotion of private sector residential and nursing home care with the implementation of the 1993 Community Care provisions of the National Health Service and Community Care Act 1990. Finally, although it is still too early to discuss whether the current 'modernisation' agenda of the current Labour government will succeed or fail to meet the demands of older people, it is worth examining what key innovations are being implemented.

4.1 Changing profiles of older people

4.1.1 Population ageing and characteristics of the older population

Population ageing

The causes of an ageing population include increased longevity, a drop in fertility and sometimes emigration. Substantial demographic changes will have profound impacts for health and social care commissioners over the next two to three decades. The number of 65+ year olds will increase slightly over the 20 years, but the numbers of 75+ and 85+ year olds will almost double (Office of Population Censuses and Surveys, 1992). Almost all developed western countries will be confronting analogous demographic change and during the two decades there will be a 13% decline in the number of 15-24 year olds (OPCS, 1992).

Characteristics of the older population

Demographic discrepancies also need to be taken into account. Foremost are gender differences, for the majority of older people are women and among the 'oldest old' the proportion increases. In the world in 1999, women comprise of 55% of those aged 60 or more years and 65% of those aged 80 and more years (UN, 1999). In the UK, women make up 68% of people aged 75 years and over, and 77% people aged 85 years and over (Government Actuary's Department, 1998). Women outlive men, but tend to experience both earlier and greater disability. Other differentials are by marital status, for a much higher proportion of men than women are married among the 60+ years population. In 1996, for those aged 65-74 years, 53% of women and 74% of men were married; and for those aged 75 years and over, 28% of women and 62% of men were married (Office for National Statistics, 1997). This has huge implications for support in old age, for men are more likely to have a spouse if support is required. On the other hand, older women are more likely to be widowed, to live alone, and to have poor health and low income (Tinker *et al.*, 2001). Other key factors have been the decline in fertility and a high divorce rate. The consequent changes in the patterns of family life have an immense impact on family care.

The findings from a recent comparison of people aged 65-84 years and aged 85 years and over indicate that very old people were more likely to have a long-standing illness which limited their activities, to be more dependent, to have more functional difficulties, and to receive more formal care services (Tinker *et al.*, 2001). Nevertheless, many very old people are fit (Jarvis *et al.*, 1996). For example, for those aged 80 years and over in England and Wales, 51% of men and 46% of women had no limiting long-standing illness, 54% of men and 33% of women had no difficulty with any domestic task, and 17% of men and 9% of women had given regular help to someone outside their household. Recent analyses of large US datasets show that for very old people, age-specific disability rates are falling and the proportion of life free of disability appears to be increasing (Crimmins, Reynolds and Saito, 1999; Freedman and Martin, 1998; Manton, Corder and Stallard, 1997).

4.1.2 Implications for formal care services

Population ageing has broad and significant implications for formal care services, family care, intergenerational links, professional training, employment patterns and the age of retirement. Nonetheless, this section will discuss only the implications for health and care services. One problem in trying to identify long-term trends is to discount short-term disturbances. The baby booms of the period after World War 2 and during the mid 1960s in the UK caused 'serous problems of alternating scarcity and surplus in the services and structures appropriate to each age group' (Coleman and Salt, 1992, p.542).

There is growing acknowledgment that the physical and mental health in which a person enters old age is decided not just by genetics but also by their preceding lifestyle and health (WHO, 1999). This has implications for policies about the welfare of the entire adult population. Promotion of active ageing, more preventive measures and a healthy lifestyle may lead to the delay or defeat of disease and disability. For those who need long term care, there is a challenge over whether to provide it at the person's home or in an institution. There are currently attempts to provide more intensive services at the person's home (Tinker, 2002). Substitutes to institutions were shown to be feasible, satisfactory and cost effective in research for the Royal Commission on Long-Term Care (Tinker *et al.*, 1999).

Related to the effects of adult lifestyles on the health of older people, differences between age groups in, for instance, the prevalence of cognitive or chronic illness, might mirror the effects of ageing. Reactive age effects are also transformed by the social environment (Victor, 1995). Such effects are, consequently, both culturally and historically particular. Although it is not easy to distinguish between the cohort effects, their influences on health and care service needs should be identified. The rise in tobacco consumption during the first half of the twentieth century, and its decline during the last quarter, are among the most obvious cohort-specific effects on the decreases and health care needs of older people. In Britain, for example, in some areas there are still high rates of respiratory conditions related to work in coal mining and cigarette smoking, not least in South Yorkshire (Warnes *et al.*, 2002).

As regards the residential and financial status of older people, it is hard to make a definite prediction but most commentators expect rising inequalities. It is likely that more older people will be affluent and that many more will be living alone in their own homes. They will be also better 'informed' about health and health–care provision and facilities. However, there will be a rising proportion who will remain financially deprived. The absolute increase in the number of the very old would certainly impinge on the needs for various health and social service provisions (Eachus *et al.*, 1996). In addition, as more people become gradually more aware of their 'rights', the expression of such needs, i.e. the demands, will also increase (Banergee, 1996).

Progress in medical research has raised hopes of cures for many hitherto disabling and incurable conditions (Banerjee, 1996). There has been substantial expansion of orthopaedic, vascular, ophthalmic, renal and cardiac services (Royal College of Physicians, 1991). Many older people do not always get comprehensive access to the newest high-tech medical facilities which are available to the young (RCP, 1991), although there are signs of better and increased service provision (Mulkerrin, 1994). This movement could be countered by rationing of health care that results from under-funding of the NHS. Despite the advances of high-tech medicine, many elderly people still have disabling conditions such as stroke disorders, arthritis or Parkinson's disease. The techniques of rehabilitation have changed and will continue to develop (Tallis, 1992). Such high-tech rehabilitation may severe more clients in need. More multidisciplinary teams will be required if there is to be further progress in rehabilitating disabled patients (Banerjee, 1996).

4.2 Health and social care for older people

Before considering the major changes in the provision of the care services initiated by the new Labour administration, it would be helpful to examine the previous arrangements for the provision of health and social care. The passing of the NHS and Community Care Act in 1990 introduced a quasi-market system, replacing planning with competition, that resulted in revolutionary changes in the way in which health and social care was organized and delivered. The effects upon older people of these major changes will be discussed in the following section.

4.2.1 Health care reform and its impact on older people

Under the internal market, hospitals were to be 'providers', and in place of getting an annual budget from the area Health Authority sold their services through contracts. In order to do this, hospitals were encouraged to become independent NHS Trusts, no longer under the management of the Health Authority. This was intended to be voluntary, but strong resistance from hospital staff and local people was disregarded (Fisher, 1999). Although in some cases the process was delayed for a year or two, all hositals had virtually become autonomous NHS Trusts by 1997. The trusts were guided by a board of appointed directors. They employed the medical and other staff, possessed the buildings and could sell them if they wanted. The 'purchasers' were primarily Health Authorities.

In parallel, General Practitioner (GP) practices were encouraged to become fundholders, with their own budgets for purchasing services from hospitals. Supported by generous grants for equipment and staff required for the additional administrative work, finally over half of them became fundholding practices (Fisher, 1999). Their budgets to purchase hospital services came from money switched from the Health Authority, which used the remainder to purchase care for the patients of GPs who had not becoming fundholders. A hospital consequently had to negotiate contracts with its local Health Authority, occasionally with neighbouring Health Authorities, and with an mounting number of discrete fundholding practices.

In the internal market for health care, GP practices that became fundholders were offered incentives to keep within 'cash limit'. This mirrored the distress of the administration with shrinking public expenditure and their wish to put welfare services within defined budgetary frameworks. To remain within the limited budget, primary care providers became more discriminating in accepting patients or, in extreme cases, tried to remove 'expensive' patients from their lists. Older people are prominent consumers and users of primary care services, as especially home visits. They are also major users of prescribed medicines. Thus, older people, particularly those with multiple disabilities, found barriers to access primary care. Not all those who were in greatest need of care were able to get access to care. An additional complication arose from the aspiration of GPs to stay within their budget, for resulted in 'undertreating' patients and an unwillingness to refer patients to hospital, as well as reduced consultation times and restricted prescribing.

Within the hospital sector, the creation of the internal market was founded upon an assumption that efficient hospitals would attract more patients and additional resources. A great deal of emphasis was put upon the internal market's ability to generate 'successful provider units'. Competition between providing units directed attention to services which were most 'efficient' and, to patient groups which were most 'profitable'. The private hospital sector certainly demonstrated this approach, with its focus upon elective surgery (Victor, 1995). The reform consequently led to the fragmentation of services and a reduced continuity of care. This had negative effects for older people who frequently present a multiplicity of health problems. In a hospital service which was constrained by a concern with efficiency, then the bed-blocking elderly patient became an easy (and stereotypically perceived) target and there was a constant pressure to reduce the length of stay in hospital.

4.2.2 Social care reform and its impact on older people

The background to the National Health Service and Community Care Act

During the 1980s, the 'residential sector' was supported by state finance which encouraged a substantial growth in the number of private care and nursing homes (Andrew and Phillips, 2002). In particular, a policy of closing long-stay hospital wards stimulated the numbers of possible clients for care homes and greatly increased the size of the market (Bartlett and Phillips, 1996; 2000). The single most important factor was the guaranteed state support for residents in private sector older people's care homes. In fact, this fiscally guaranteed the residential sector and lessened the risk of such businesses. There was a rapid expansion. From November 1983 to 1993, any person with less than a specific amount of savings and capital (£16000 in 1992) was eligible for full state benefits which would include care-home-fees without assessment and additional means-testing. The numbers of private residential homes in the UK rose from 2255 in 1979 to 7240 in 1986, an annual increase of over 18% (Phillips *et al.*, 1988). Finance supported by the social security budget for residential care for older people and people with physical and mental disabilities increased from £6 million in 1978 to £1.3 billion in 1991 (Walker, 1993).

The growth indicated that many more people than before would choose or accept private residential care. In fact, the residential care business became well known for its financial security and profit-making promise. The private residential sector was always in part privately financed, even if privately-paying residents were and remain fewer than publicly-financed residents. For instance, Phillips and Vincent (1988) found

50% of all care homes to have over half their residents publicly-supported, whilst 25% had more than three-quarters of their residents publicly-supported. As a result, by the late 1980s public finance has contributed a large proportion of the income of many care homes.

The government hoped to keep prices down, to enhance the standards of care by market competition, and to reduce direct public expenditure in local authorities' older people's homes and long-stay geriatric wards by ending the 'perverse incentive' of delivering free NHS long-term care even to those with capital savings (Impallomeni and Starr, 1995). Most of these hopes were however not accomplished. Despite the decline in direct public expenditure on the care of older people, indirect public expenditure increased, and greater numbers of older people were institutionalized. It was also found that means-testing saved little money, as most older people had minuscule savings to finance their residential care (Impallomeni and Starr, 1995). It was later estimated that only 8 per cent of single older people could pay for residential home care and 4 per cent for nursing home care (OPCS, 1993).

Some private care-homes introduced higher standards of care, pricing themselves out of the range of social service funding, and mostly attracting the young old. Inner urban areas, with their many poor older people and high property prices, saw fewer private homes created (Age Concern, 1994). Some elderly people, especially in London, were moved miles away from where they had lived and from their social networks, family and friends: this was not an enhancement of choice (Impallomeni and Starr, 1995).

The impacts of the Community Care Act on older people

During the 1980s, the private residential sector for older people had the benefit of generous state financial support. It caused the escalating public expenditure which was problematic with government financial policy. In this context, Roy Griffiths was asked by the government to review long-term / community care and produced the Griffiths report. This led to the *1993 community care provisions of the 1990 NHS Act* which created a quasi-market in social care in 1993. Local authority social services departments held 'community care' budgets. They assessed dependent elderly people's needs, designed care plans and 'packages' and purchased the care from public, for-profit and voluntary sector providers. Care homes had to compete amongst each other for a smaller number of consumers subsidised by limited local authority budgets (Andrew and Phillips, 2002). A main element of the community care reforms was then the encouragement of non-state agencies in the provision of social care and the establishment of a 'mixed economy' of provision. The underlying rationale for this model of private and voluntary care provision was increased choice enhanced inefficiency (the theoretical consequence of competition between providers and services), and greater orientation to consumers. These supposed gains became the standard justification for market reforms.

An obvious policy aim was to keep frail older people in their own homes supported by community services (Department of Health, 1989; Raynes, 1998) and was to discontinue the perverse incentive of easier institutionalization in private homes, (DoH, 1990) by transferring DSS (Department of Social Security) income support benefits to local authority social services departments; they could currently use this money, called special transitional grant (STG), to pay for domiciliary community care and maintain frail older people in their own homes (Impallomeni and Starr, 1995). Having residential homes as a 'last resort' alternative was apparent with the philosophy of care in the community. However, Wistow (1995a; 1995b) indicated that the direct origins of the 1993 reforms was related to the need to cash-limit social security spending on residential care.

Care in the community for frail older people became the new clear goal and recognised the desire of older people to remain at home with support. Eighty-five per cent of STG was to be spent on purchasing private domiciliary services and residents' fees in care homes, and local authorities were also instructed to pay for these before funding their own care homes (Age concern, 1994). It was estimated that if the old rules had continued, their would have been a additional 110,000 new residents in private care and nursing homes in the United Kingdom during 1993-1994, but that the new rules would decrease these to about 64,000 (a diversion of 42 per cent to domiciliary care) (Kubisa, 1994)

There was however some well-justified disappointment with the implementation of the new 'community care' arrangements. Above all, concerns expressed about the fragmented and uneven way that care was delivered and with the lack of explicit objectives (Victor, 1995). The growth of private and voluntary care organisations raised concerns about the quality of care and as to how such agencies would be managed and staffed. In fact, the 'standard' of care package that was state-funded has never been high. Moreover, geographical inequalities in the quantity and quality of care provided increased and there were socially-based inequalities in access to care. Middle-class people gained disproportionately from the services offered by the welfare state. Under the market-orientated system, neither purchasers nor providers of care endeavored to serve the groups which had fared badly under the care system (Victor, 1995). The priority to expand the independent sector and 'efficient' services did nothing to improve access to care by the most deprived.

4.2.3 Community care *versus* institutional care

The relative merits of 'residential care *versus* community care' has been a constant debate in both political and academic areas. The criticism of residential care has been two-fold. One strand of criticism has emphasised on standards: the incapability of communal living environments to provide independence and preference for residents and to respect their civil liberties, and the incapacity of regulating bodies to guarantee adequate quality (Andrew and Phillips, 2002). For instance, Peace *et al.* (1997) argued that, despite greater regulation, residential care still de-personalises older people. Most recently, a *Help the Aged* report (Fisk, 1999) proposed that residential care has reached 'the end of the line'. Homes are condemned for reproducing institutional models of provision that borrow from historical poor law models. A second strand of criticism considered care homes as places of shame and social marginalization. From this viewpoint, no matter how much standards may be raised over time, residential homes would forever have negative associations that marginalize older people.

On the other hand, the history over more than 30 years of long-term care for older people in the United Kingdom demonstrates a constant and almost universal view among practitioners, policy makers and academic analysts of the superiority of community care, and specifically of keeping individuals in their own homes supported by community-based domiciliary, day centre and clinic services and, informal carers. A result of this policy has been the retrenchment and stigmatization of all types of institutional care (care in long-stay wards of general hospitals, nursing homes, and residential care homes) (Dalley, 2000). This negative consensus has its roots predominantly in the de-institutionalization movement that began in the 1960s with closing the large, long-stay mental hospitals or asylums. Long-stay institutions for older people were deeply affected by this innovative philosophy. Long-stay hospital beds for older people, for instance, have been cut back considerably over the last 20 years. It became an unchallenged or taken-for-granted axiom that long hospital stays were to be avoided. This belief has translated into the great stress currently placed on the early discharge of older people admitted to hospital for acute care. Ironically, however, the cut-backs in other types of long stay institutions for older people has reduced the number of places to which people can be discharged.

As the de-institutionalisation movement extended, policy makers and service providers developed community-based alternative services. These were previously available but frequently rudimentary and fragmented. It was not, however the straightforward substitution of one type of service provision by another. The rhetoric and principles associated with the transition reached a high point in the 1980 with the election of a Conservative government. The government policy documents[1] of the time reveal the policy and expectation of the government that individuals and their families should accept much of the responsibility for the care and support of dependent older people (and others). Long-term care was constructed as a private responsibility, with the public welfare state taking a supportive role (Dalley, 1996).

The harsh moral mood that distinguished the Thatcher years of government highlighted the requirement for self-reliance and for the individual to secure his or her own financial and practical support. The state would not intrude into the private sphere needlessly. The promotion of personal responsibility associated with the political right corresponded with the central tenets of the community care and de-institutionalisation movement. The protection of privacy, dignity, and autonomy could best be accomplished by keeping people in their own homes and as far as possible making them responsible for their own support.

This ideology and policy had enormous effects for the individuals concerned and their relatives. Community care did not however develop in quite the way imagined at the beginning of the 1980s. The most astonishing service change during the subsequent 15 years has been the enormous growth in privately-delivered residential and nursing home care. While National Health Service beds were shut, the provision transferred to the private sector. Most analyses of this trend have indicated that the explanation was exclusively the perverse incentive of social security fee-subsidies. These encouraged community care managers and their clients to opt for state-supported

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[1] Department of Health (1989). *Community care in the next decade and beyond.* London, Department of Health.

Department of Health and Social Services (1988) *Community Care. Agenda for action. A report to the Secretary of State for Social Services* (by Sir Roy Griffiths). London, H.M.S.O.

Equal Opportunities Commission (1988) *Response to Sir Roy Griffith's report, Community care agenda for action.* Manchester, Equal Opportunities Commission.

The next three are not government documents, but are relevant and useful references:

Bulmer, M (1987) *The Social Basis of Community Care.* London, Allen and Unwin.

Dalley, G. (1988) *Ideologies of caring. rethinking community and collectivism.* Basingstoke, Macmillan Education.

Hughes, B. (1993) *Older people and community care. critical theory and practice.* Buckingham, Open University Press.

institutional care rather than home-based care. Local government social services departments (which are responsible for community care) saved funds because social security benefits are paid from a national budget rather than the local authority's. Much of the key several administrative orders at the end of the 1980s sought to control the escalation of the expenditure on care-home fees. What was of least concern was whether or not people preferred institutional living to the alternative of staying at home (Dalley, 1996).

Stopping increasing institutionalized people has been accomplished by various means. Among the various means, most important approach was to regulate tightly access to care through the introduction of assessment procedures-both clinical and financial which facilitate local government (the agency that pays for care for those who cannot pay for themselves) to limit people moving into institutional care through its gate keeping role.

4.2.4 Community care: 'in' or 'by' the community?

While there is no dispute that acute health care has to be delivered by competent clinicians, on the other hand, for the provision of social care there are ambiguities and differing attitudes towards the giving and receiving of care. To the argument about the relationship between formal and informal care, Roy Griffiths made his view very clear that informal carers are the central and leading supporters of older people:

> Publicly provided services constitute only a small part of the total care provided to people in need. Families, friends and neighbours and other local people provided the majority of care in response to needs which they are uniquely well placed to identify and respond to (Griffiths, 1988, p. 5).

This attitude was represented in the subsequent White Paper as 'the great bulk of the care is provided by friends, family and neighbours' (DOH 1989, p. 4). In this conception, the state is no more than a residual provider of social care, and community care becomes care by the community. The informal sector, and families particularly, are certainly vital to the care of older people. Nonetheless, there is evidence that older people prefer that certain types of care are provided by professionals rather than family members and that this preference is spreading (Victor, 1995). In Norway, Daatland (1990) found a growing preference amongst older people for state-support rather than family-support. Correspondingly, West *et al.* (1984) and Salvage *et al.* (1989) have both reported the preference for community-based professional care rather than either institutional or exclusively informal care.

Overall, older people clearly favour care 'in' the community rather than 'by' the lay community. This may partly reflect the lessening chances that older people have for support by family members (apart from spouses) at times of crisis and dependency. Many say that they do not want their children's family-raising responsibilities or careers to be disrupted by the demanding and stressful responsibility of providing intensive care to a dependent older person. To assume that future generations of children or extended family members are capable of offering intensive care fails to recognise the altering nature of family values, structures and functions.

4.2.5 Changes in care services for older people by the new Labour administration

Concerns with the quality of residential and nursing home care are perennial but were exceptionally high in the early 1980s. The government commissioned a review by Baroness Avebury which was conducted in association with the Centre for Policy on Ageing. The resulting report, *Home Life: A code of practice for residential care* (Department of Health and Social Security and Centre for Policy on Ageing 1984) led to a new system of registration, regulation and inspection through the *Registered Homes Act 1984*. This was revised in 1992 by the *Registered Homes (Amendment) Act 1991 and Commencement Order 1992 Residential Care Homes (Amendment) (no. 2) Regulations 1992*. The system retained separate inspection units run by the National Health Service for its own homes and by local authorities for other homes. In practice, local authority homes were not subject to the same regime or registration and inspection as private sector and voluntary homes. The main weakness of the system, however, was that it was insufficiently resourced. Not only were there too few staff, local authorities became extremely cautious about enforcing the regulations and closures in the face of legal actions by proprietors and some very expensive settlements. Renewed guidance was issued by the NHS Executive in 1995.

While the conservative administrations of the 1980s and 1990s undertook major reforms of long-term, social and nursing care for dependent older people, as the previous section has made clear, the new arrangements were expensive and sometimes perverse, in that some people with high care needs were denied state support. The media featured stories of older people having to sell their homes to pay residential care fees. Newspapers ran articles on elderly homeowners, who had paid tax and national insurance all their lives, and who could now no longer bequeath the homes they'd worked hard to buy to their children (Steele, 2001). Those who were cared for in hospitals received free care, but those with conditions such as Alzheimer's disease who were cared for 'in the community', including in residential or nursing homes, were means-tested and often ended up paying contributions to their fees.

When the 'New Labour' administration was elected in 1997, the issues were perceived as a political priority, and the government quickly took the initiative. It did not however have a policy for change or improvement, so it followed the usual practice in Britain. When a British government does not know what to do and the government quickly set up the *Royal Commission on the Funding of Long-Term Care* in late 1997, headed by Sir Stewart Sutherland to investigate and make recommendations about the issues. It issued its report in March 1999 (Sutherland, 1999), but few of the recommendations were adopted in England and Wales. The report supported free nursing and personal care, but the government has only accepted the provision of free nursing care for older people with long-term care-needs. The government has however resulted the idea of free personal care and has so far failed to respond. To make personal care free in domestic or residential settings for those in need was the most controversial recommendation (and was not supported by a minority report of the commissioners) because this has huge implications for taxation and has not yet been met with enthusiasm by the government. Free personal care has however been introduced in Scotland from 1st July 2002. It has greatly increased the public interest and pressure on the government facing calls to make free personal care for the older people available across the UK. The Royal Commission moreover recommended the establishment of a *National Care Commission* to monitor demographic and spending trends, keep under review the market for care, and represent consumers' interest. This recommendation has been implemented.

As the role of the private sector in the provision of long-term care has expanded, the timeless concerns about the quality of care in these settings have not decreased. The sector had been regulated in England and Wales by the *Registered Homes Act 1984*, with a voluntary code of practice for residential and nursing homes (Centre for Policy on Ageing, 1996) and national guidelines for nursing homes. Nevertheless, legislation and guidance has concentrated mainly on the structural and process aspects of care, with less consideration of the quality of life of the residents. A main problem has been the inconsistent way in which guidance has been understood by inspectors across the country under the remit of local authorities and health authorities (Royal College of Nursing, 1994). The 'registration and inspection' units were also dissuaded from assertive control of the sector by the high costs of court actions, often by proprietors threatened with closure claiming that the bureaucracy was unreasonably 'restraining trade' (Phillips *et al.*, 1987; Phillips and Vincent, 1988).

This approach caused unacceptable differences in standards of care across the country with a high degree of confusion for both service providers and service users. The development of *National Required Standards* was therefore commissioned by the Department of Health and undertaken by the Centre for Policy on Ageing. The standards were then announced by the department in November 1999 for consultation, initiated in April 2002, but following furious protests from the industry, largely withdrawn within three months. The standards cover a home's physical environment, management, policies, staffing, and information. Moreover, the standards deal with residents' rights, daily life, food and mealtimes, health and personal care, and death and dying. To address the variations in inspection processes and outcomes across the country, a new *National Care Standards Commission* has taken over the local authority and NHS 'registration and inspection units' responsibilities.

Another significant challenge for policy development concerns users' views and opinions. A *Long-Term Care Charter* was announced for consultation in 1999. This sets out what users are to expect from health, social services and housing. It embraces six important areas: finding out about services; understandings users' needs; the right place to live; maintaining health; maintaining independence; help for caregivers; and complaints. Widespread questions concerning the health and social care divide are now being tackled in the future planning of older people's services in the UK. Alongside the *Long-Term Care Charter*, plans for the development of *National Service Frameworks* and *Bettter Services for Vulnerable People* in England (Department of Health, 1997) have been introduced to address the problems of service coordination. The Department of Health (1998) has published plans for pooled budgets and commissioning between health and social services and integrated provision to improved joint working.

A leading domestic political priority of the Blair administrations has been to improve the National Health Service. In order to improve the quality and efficiency of services, the current Labour government set out its proposals for the renovation of the health services in the White Paper, *The New NHS: Modern. Dependable* (Department of Health, 1997). In the reform of NHS, the significant major changes such as the introduction of primary care NHS Trusts (PCTs) and a new statutory liability for quality of care provision have been introduced. The internal market (which was initiated by the Conservative government) was eliminated and changed to an integrated market, but simultaneously, the split between purchasing of hospital care and its provision is preserved by a separation between the roles of purchasing and providing institutions (Department of Health, 1997).

To overcome the fragmented service, the new NHS encouraged collaboration in planning and providing health and social care services through a jointly agreed local Health Improvement Programmes. The HIMP is led by the Health Authority and involves NHS Hospital Trusts, Primary Care Trusts and other primary care professionals working in partnership with the local authority and other local interests (DOH, 1997). Also, to promote efficiency in all areas of NHS activity, long-term agreements between Health Authorities, Primary Care Trusts and NHS Hospital Trusts has been established. Long-term agreements will replace the annual contracts of the internal market and may develop better integrated care through improved communication between primary and secondary care. Furthermore, the distribution of resources through Health Authorities to inclusive Primary Care Trusts and their new unified budgets covering hospital and community services, GP prescribing and the general practice infrastructure have been established to promote access to high quality care. At the same time, to promote integration between health and social services, the Government has required *Joint Investment Plans* from 1999-2000 for continuing and integrated care which can meet the multiple needs of the population.

A new statutory duty for quality has been introduced through the National Service Frameworks, to ensure consistency across services with regard to access and quality. The NSFs for Mental Health and for Coronary Heart Disease were introduced in 1999. The *National Service Framework for Older People* was introduced in 2001 (Department of Health, 2001). The key objective is to set up 'standards' that stop discrimination related to age, gender, race, location, and place – home, hospital or nursing home – and physical or mental disability. Major indicators take account of lessening levels of disability, ensuring that the expectations of older people are met, that there is a genuine partnership with carers, and that staff knowledge, skills and attitudes encourage pride in performance. The NSF represents an unprecedented attempt to end the marginalisation of older people's services in Britain.

Moreover, a new *National Institute for Clinical Excellence*[2] (NICE) is to give an effective lead on clinical and cost-effectiveness, formulating new guidelines and ensuring they reach all parts of the health service. In order to ensure the quality of

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[2] NICE is part of the NHS. It is the independent organisation responsible for providing national guidance on treatments and care for those using the NHS in England and Wales. Its guidance is for healthcare professionals and patients and their carers, to help them make decisions about treatment and healthcare.

health services, the Government additionally created a new *Commission for Health Improvement,* which will complement the introduction of clinical governance arrangements to reduce the variable quality of clinical performance. The Commission may take up an agreed programme of systematic service reviews, following through implementation of the National Service Frameworks and the guidelines developed by the Institute.

The development of primary care aims to deliver better care at lower cost – a goal sought by every government and every country. Without doubt, the new NHS reforms represent a great effort to improve primary care through the transitional PCGs (Primary Care Groups) and now attained PCTs (Primary Care Trusts). In these larger units, GPs and community nurses and other professionals work together, and joint working between heath and social services is encouraged. The PCTs are developing frameworks for cooperation with non-government agencies, and they are required to contribute to the Health Authority's Health Improvement Programmes. All these initiatives seek to ensure that the perspectives of the local community and the experience of patients are acted upon. In 2001, 481 PCGs ranging in size from 50,000 to 250,000 patients were formed in England (Andrew *et al.*, 2001). Primary Care Trusts are expected to solve the problems with fragmentation and variability in the provision of primary and community services, to meet the health needs of people and improve the cost effectiveness. On the other hand, GPs' concerns about their role in the Trusts and the needs to challenge and alter conventional attitudes and relationships especially, between GPs and nurses are also expected to form an important part of the managerial challenge for organisational change (Mahon and Garrod, 2000).

4.2.6 Conclusions

The *National Plan* (Department of Health, 2000b) and *National Service Framework for Older People* (Department of Health, 2001) set out a programme of action and reform for older people's services in the UK. They identify national standards intended to modernise NHS and social services and promote new ways of working. The rapid pace of reform implies major changes in the organization and delivery of care services for frail older people. While it is still too early to evaluate the outcomes, it remains unclear whether the reforms will create a satisfactory and comprehensive system of treatment and care. The intended shift from institutional to community-based services for older people has not yet taken place. Uncertainties remain regarding policy implementation at a local level (Bartlett and Phillips, 2000).

Emergency hospital admissions and pressures on acute beds have been among the unintended outcomes of recent policy changes. Besides, day care and domiciliary packages are slow to develop in the private sector; the present funding arrangements in local authorities produce perverse incentives that encouraging the use of residential and nursing home care (Henwood and Wistow, 1999). There are increasing concerns about the capacity of the independent sector to meet the needs of the growing numbers of highly dependent older people. Staff recruitment and retention problems, poor pay and conditions, lack of career prospects, and the low status of work with older people are constant impediments to the effective provision of long-term care (Bartlett and Burnip, 1998; O'Kell, 2002).

In the future, a greater proportion of households will consist of single old people or older couples without children. If they have illness or disability, community-based services are a questionable substitute for residential care. The ending of universal access to NHS long-term care for older people and the limited availability of home-based care have reduced the choice for consumers and their families, despite the consistently stated converse aim of care reforms.

In this context, the development of new and innovative models of care is essential to meet the needs of growing frail older people. Many agencies, policy pronouncements and specific reforms have proclaimed the need for innovative services. The *1999 NHS Plan* emphasized collaboration in planning and providing health and social care services and the development of innovative services for older people. The *NSF for Older People* and the report by *Royal Commission on Long-term Care* also confirmed the need for innovative services for frail older people. A combination of this consensus, and the urgent priority of preventing older patients with chronic but not acute needs from occupying hospital beds has led to the promotion of 'intermediate care'. The backgrounds, aims, types of schemes, and expected service outcomes of this latest policy enthusiasm will be further discussed in the next chapter.

Chapter 5

Current priorities and innovative care services for older people

Chapter 4 showed the provision of formal care services for older people in Britain in several ways fails to respond to the care needs of older people. Acceptance of this deficiency is one reason for the rising interest in innovative services for older people and for the development of 'intermediate care' services throughout the UK. The main aims of this chapter are to review the background of the innovative service developments and to assess the case for the large investment in them at this stage in the development of care services for chronically sick and older people.

A literature review has been carried out using the data was collected from CINAHL, MEDLINE and the Cochrane database of systematic reviews from 1981 to May 2003. Some cited references in the identified references were also inspected. This chapter first discusses the political and medical and care-practise backgrounds to the rising interest in intermediate care. The aims and diversity of intermediate care services and the evidence on service outcomes are then described. Finally, the implications for further service developments and further research will be discussed.

5.1 Background to the rising interest in intermediate care services

The combination of an ageing population and the remarkable reduction in acute hospital beds has led to problems with hospital discharge and pressures on accident and emergency wards. The prevailing emphasis upon the 'efficiency' of the NHS care system means that many older people with less severe or less acute illness are denied care in acute hospitals. Nor were their care needs entirely met by community-based primary care. Consequently, there was a good case for innovative services, and this was reinforced by the claim that 'intermediate care' would have a 'prevention' role. Announcements of the schemes were important nationally and locally for the 'media image' of the NHS and for the politics of modernising the NHS.

5.1.1 Hospital bed pressures and ageing population

In recent years, there has been a remarkable reduction in the number of hospital beds in the United Kingdom. For example, from 1977/78 to 1997/98, acute beds reduced from 155,000 to 108,000, while geriatric beds fell from 56,000 to 30,000. Since 1970, the number of beds in the acute, geriatric and maternity specialities has fallen from 240,000 to 150,000 (Vaughan and Lathlean, 1999). The pressures to increase the intensity of hospital bed use (Harrison, Hamblin and Boyle, 1995) have been associated with the shortage of junior doctors and nurses (Vaughan, Steiner and Hanford, 1999), which has been exacerbated by changes in junior doctors' hours (NHS Management Executive, 1991).

Despite the reduction in available beds, general and acute[1] ordinary admissions have increased by 1.8% a year (Vaughan and Lathlean, 1999). Since 1975, ordinary general and acute admission rates per thousand people aged 65 years and over have increased by on average 3.5% a year and 1.6% for the all-age population (Vaughan and Lathlean, 1999). The pressure to increase the intensity of acute hospital bed use has therefore been substantial.

Great Britain now has approximately half the number of hospital beds per patients as France or Germany and the lowest ratio of doctors per 1000 patients among the industrial countries (Mulley, 2001). Nonetheless, the number of ill older people referred to hospital has increased, raising the care expectations of patients and their families. Moreover, current health care provision has to cope with pronounced seasonal fluctuations, particularly during the winter months when there is a marked increase in respiratory infections and other diseases. As a result, acute hospitals have found it difficult to manage large numbers of ill older people and has decreased capacity for older patients with multiple chronic conditions including the 'undesirable' older patients that are frequently called 'bed blockers'.

To reduce the problems deriving from the reduction in available hospital beds, patients on average spend less time in hospital for any given illness episode than five years ago (Parker *et al.*, 2000). For instance, from 1981 to 1996/7, the average acute duration of stay (per finished consultant episode) decreased from 9.3 to 5.0 days, while the average length of stay in a geriatric unit decreased from 66.1 to 18.6 days. This means that the majority of discharged older people need longer periods of recuperation in the community.

5.1.2 Increasing demands of emergency service

Alongside the problems attending the decrease in hospital beds, hospital Accident and Emergency (A&E) departments are also under pressure from increasing demand and shortages of staff (Audit Commission, 2001). A recent report by the Audit Commission

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[1] General and acute is defined as acute plus geriatric excluding well babies.

(2001) indicated that in 2000 the waiting both to see a doctor and to be admitted to hospital had increased since 1996. The lack of available hospital beds delays admission, takes up cubicles and staff time in A&E, and delays the assessment and treatment of older patients.

Older people are frequent users of A&E departments because they experience a high incidence of accidents. According to a multi-centre study in United States cities, older people comprised 12% of the population but 15% of A&E attendances (although different entitlements and access arrangements may invalidate A&E comparisons between the USA and UK). (Strange, Chen and Sanders, 1992). A higher attendance rate by very old patients has also been shown in Nottingham and Leeds (Dove and Dave, 1986; Wass and Zoltie, 1996). The increasing average age of older people has been related to the rising rate of attendance, particularly, the growing number aged over 80 years (Dove and Dave, 1986; Wass and Zoltie, 1996). Wass and Zoltie (1996) found a 30% rise over four years in A&E attendance amongst those aged 80 years and over in Leeds (1990-1994).

In a British study, the high rate of A&E attendance by older people was matched only by young men who 'misuse' the service (Dale *et al.*, 1995). From the findings of this study, several markers of older people's A&E use suggests that their attendance rate reflects a high incidence of serious illness and accidents, while young adults were more likely to attend A&E for primary care.[2] It indicated that a higher proportion of older than younger people's A&E visits were 'appropriate'. Similarly, a study undertaken in the United States suggested that A&E attenders aged over 65 years were more likely to require comprehensive emergency services than young adult attenders (aged under 65 years) (Strange *et al.*, 1992). A British study also showed that there were significant differences between young (under 65 years) and older people discharged from A&E (Burns, 2001). One-fifth of older patients had difficulties in self care, compared with one-tenth of younger people. Moreover, more of the older patients lived alone (one-third compared to one-sixth of young adults).

5.1.3 Seasonal pressures

During recent years there have persistent difficulties in British acute hospitals in coping with the increases in winter demands. The term used to refer to these problems is 'winter pressures'. In particular, the hospitals struggle to admit and treat elderly patients with respiratory infections, because of the shortage of the acute beds

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[2] Primary care was defined to include non-emergency problems that could have been treated.

(Woodman, 2000). Besides, primary care (GPs) find it difficult to cope with unusual peak demands, especially at holiday times (Christmas / New Year). The delays and the inability to provide treatment have led to bad media coverage, especially at the end of 1999 when there were scandalised accounts of long waits in emergency departments, patients shunted around the system and, tragically, the death of patients awaiting admission to hospital. The failures were severe, and the greatly embarrassed the government. Consequently, the Department of Health ordered the establishment of Winter Planning Groups to be led by the Chief Executives of all English Health Authorities (NHS Executive, 2000a).

The long-standing problem of high or 'excess' winter mortality in the UK persists. The mean excess winter death index (the percentage excess of deaths in the four winter months (December to March) compared with the average in the proceeding and following four months) for eight winters (1976 to 1984) was 21 in England and Wales and 20 in Scotland, much higher than in Canada, Finland, Germany and the United States which have colder winters (7, 8, 8 and 9% respectively) (Curwen, 1991). During the 1996/97 winter, the number of excess deaths in England and Wales was about 50,000, with 48% caused by respiratory infections and 36% to circulatory diseases. The excess winter deaths were almost entirely older people (Christophersen, 1997).

5.1.4 Increased needs for alternative care to hospital and unmet needs by community based primary care services

There is a widespread view that some older patients are unsuitably admitted into acute care settings and that some stay in acute hospitals longer than is necessary or desirable (Audit Commission, 1992; Evans and Griffiths, 1994; DoH, 2000a). According to the Audit Commission (1992), 49% of people in acute medical beds were 'misplaced', while recent local surveys by both King's Healthcare and the Newport Health Commission established the figure at about 37% (Vaughan, 1998). A recent systematic review commissioned by the *National Bed Inquiry* (NBI) at the University of York found that around 20% of older people's bed days were possibly unsuitable and would be unnecessary if alternative care services were in place (McDonagh, Smith and Goddard, 2000). Patients whose medical condition has stabilised but are not sufficiently recovered to live independently have care needs that are most appropriately met by neither acute or primary health care settings as currently organised.

A recent report argued that presently too many older people are admitted to hospital because of the shortage of community-based services that would better meet their needs (Luff *et al.*, 2000). The NBI review found that a lack of housing and community support was the most generally cited reason for delayed discharge (McDonagh, Smith and Goddard, 2000). An Audit Commission (1997) report also indicated that too little investment in preventative and rehabilitative services has been a factor in the increase of both unplanned admissions of older people to hospital and premature admissions to long-term residential care.

It should be remembered that an unnecessary hospital admission has a harmful effect on individual's ability to return to independence. A hospital admission may disrupt the social network, and lead to disorientation and hospital-acquired infections (Luff *et al.*, 2000). The report finally concluded that many older people actually prefer alternatives to hospital admission. Another report estimated that 8% of medical admissions could have been managed differently if alternative services had been available (HaCCRU, 1997). These various reports demonstrate that there are several reasons for the increasing demand for alternatives to hospital care for older people.

5.1.5 Increased service users' expectations and policy developments for the 'efficient' of the NHS care system

Consumerist attitudes have a rising influence on health care policy and practice. Patients and the general public increasingly demand 'informed choice' and alternative ways in the management of their own health with expectation (Henwood, 1995). Changing values about health care are increasing the demands for innovative services. The *NHS Plan* promised increased collaboration in planning and providing health and social care services, and required health and local authorities to develop joint investment plans (Department of Health, 2000b). The pressure to develop more integrated care requires more innovations in services for older people.

In summary, several facts and perceptions about the problems of current patterns of provision have raised interest in innovative 'intermediate care' services. While there is no consensus about what kinds of care schemes belong to intermediate care, nor whether the new schemes should substitute or supplement existing services. There are disagreements about whether intermediate care schemes are a completely new idea or more a re-naming of existing services. There is insufficient evidence from which to develop models of the new services. There is a need to define the concept and purpose of intermediate care, and to monitor closely implemented intermediate care schemes and collate the evidence about their service and patient outcomes.

5.2 The aims and models of intermediate care

5.2.1 The aims of intermediate care

There are various definitions of 'intermediate care'. Americans use the term for all care between the intensive care unit and the 'general floor' or ward (Gerber, 1999; Cheng, Byrick and Knobel, 1999). Japanese 'intermediate care', which was introduced in 1987, mainly focuses on post-acute hospital care: nursing care and rehabilitation to help discharged older patients (Ishizaki *et al*, 1995; Ishizaki, Kobayashi and Tamiya, 1998; Watanabe *et al.*, 1999). Japanese intermediate care facilities generally provide much longer episodes of care than in Britain (Ishizaki, Kobayashi and Tamiya, 1998). A quarter of the users of 'geriatric intermediate care' facilities stayed for over one year. In Australia, hospital-at-home care for post-acute care has been introduced to promote early discharge (Ting *et al.*, 1998; Montalto, 1998).

British intermediate care services have more varied objectives and forms than those of other countries. The common general aim, however, is to provide intensive therapy to maximise the patient's capacity to live independently, to improve the quality of their lives, and to provide the opportunity for them to enhance their self-care skills so that they can maintain their own health in the long-term. Such aims while comprehensive are vague. According to Vaughan (1998), intermediate care provides services for people who need help during the transition between medical dependence and personal independence, but who do not need the specialist medical treatment or intervention of an acute hospital setting. From a review of the literature, Steiner (2001) states that the model of care follows nursing rather than hospital medical practice, in that patients are regarded holistically and 'care' rather than 'cure' dominates. A third theme is that care is provided in or near the patient's home, or in a home-like environment.

A significant objective in the British schemes is to maximise patients' and families' access, comfort and control. Intermediate care practitioners emphasise holistic assessment, frequent re-assessment, flexible input from a multi-professional team and, importantly, a plan either to keep the patient out of hospital in the first place or to send the patient home as quickly as possible.

5.2.2 Models of intermediate care

Many and diverse intermediate care schemes to avoid or reduce periods of hospitalisation have been initiated in the last five years (Parker *et al.*, 1999), although one commentator alleges that 'some are old ideas rebranded' (MacMahon, 2001).

Among the pre-existing service places which have been used to provide alternatives to the acute hospital ward are general practitioner and consultant-managed beds in community hospitals, nursing homes and day hospitals (Parker *et al.*, 2000). Community nurses service for people returning home from hospital are also being developed for a greater range of care needs than in the past.

The types of new provision vary in quality by health authority area. The following synthesis concentrates upon the most common schemes. Three main types can be distinguished: admission-avoidance schemes, post-acute care schemes, and combined-care schemes that offer various intermediate care services.

Admission-avoidance schemes

These schemes are based on the assumption that many of the patients admitted to hospitals do not need their specialised facilities but have substantial care needs and could be addressed by more effective community health and social services that sustain people at home. For those people, there are three types of admission-avoidance schemes: rapid response services, GP nursing-home beds, and district nurse-led beds.

A rapid response service is usually provided through telephone triage, a method of crisis management designed to avoid hospital admissions when possible. This scheme is not only nurse-led but usually provided with heath and social care inputs. Since the first rapid response scheme was initiated in Milton Keynes in 1996, similar schemes have been established in most parts of the country (Vaughan and Lathlean, 1999). However, there are many different names for the schemes as well as different eligibility criteria for the patients, different locations for the care, different available service durations, different referral pathways or ways to access the scheme, and different team professions.

A small number of GP nursing home beds are held by GP practices or Primary Care Trusts for short-stay observation and recuperation (to avoid hospital admission) or to help early discharge. District nurse-led beds were recently introduced to reduce the number of hospital admissions of frail older people. The district nurses are responsible for admission, care and discharge, and give them the opportunity to admit patients requiring short-term nursing help from their community caseloads into a community hospital. In one such scheme, some younger people with multiple sclerosis were admitted for respite care, but most patients were aged over 65 years and with chronic condition (Shepperdson *et al.*, 2001).

Post-acute care schemes

Early discharge schemes provide care in the home or in managed care units to people who would otherwise be in hospital, the objective being to delay or to avoid admission or to help early discharge. These schemes may benefit the health service through a reduction or the avoidance of hospital stay, a reduction in elective surgical waiting lists (through earlier discharge), and a reduction in the cost of care (by avoiding delayed discharge). The patients may be helped by these schemes, by avoiding complications with hospitalisation, including pressure sores, falls and cross infections, maximising independence with detecting the changed need for aids and adaptation in the home, and improvements in morale and well-being by involving patients in their care in their own home (Corrado, 2001).

The currently, available models of these intermediate care schemes are nurse-led units, supported discharge, hospital-at-home and social services rehabilitation. Nurse-led in-patient beds have precise clinical objectives, to improve functional status and the capacity to live independently by intensive therapeutic input. They mange the admissions pre-identified discharge destinations, the rehabilitative possibilities and ascertain a patient's needs for nursing care rather than medical care. Supported-discharge schemes begin with early discharge-planning and generally include multi-disciplinary assessment, home visits and arrangements for supportive services. These schemes normally involve primary care professionals, geriatricians, and social services with combined health and social lead practitioners.

Compared with other intermediate care schemes, hospital-at-home schemes have been established in many other countries. For example, a scheme began in 1961 in Bayonne and Paris, originally to provide terminal care, and later extended to other patients such as older and disabled people (Morris, 1983). The first British scheme, in Peterborough, was introduced in 1978 with the help of charitable funding (Mowat and Morgan, 1982). Hospital-at-home schemes are becoming popular worldwide as an alternative to hospital care (Shepperd and Iliffe, 1996; Marks, 1991). A British review identified 139 schemes in operation and 100 planned (Shepperd and Iliffe, 1996). In some countries, hospital-at-home has alternative names such as 'extra-mural hospital' or 'hospital in the home' (Shepperd and Iliffe, 1996; Marks, 1991).

Many variations have been found between and within countries. Some schemes involve assertive interventions in the home, including ventilation, and antibiotic and anticoagulant therapy (Shepperd and Iliffe, 1996; Marks, 1991; Montalto, 1998; Ting *et al.*, 1998). According to an Australian study, a hospital-at-home scheme can treat several potentially life-threatening medical conditions, such as infection necessitating intravenous antibiotics and deep venous thrombosis (Montalto, 1998; Ting *et al.*, 1998). British hospital-at-home services have however mainly emphasised nursing care and rehabilitation.

Social service rehabilitation schemes for post-acute older patients is provided by community resource centres, many of which were originally residential care-homes. Since residential care has been steadily moving into the independent sector, the local authority owned premises, managed by social services, have been changing residential care provision to bedded or day centre rehabilitation. Such care schemes, not only social services but also various therapists including, physiotherapy, occupational therapy, and speech therapy.

Combined-care schemes offering diverse intermediate care services

Some of existing and new services provide intensive therapeutic rehabilitation and convalescence care. Such services have a long history in community hospitals and community care centres (resource centres).

Community hospitals operate either as a 'branch' of an acute National Health Service Trust or as an extension of primary care. In order to relieve a district acute hospital's beds, many community hospitals provide GP beds to which patients are generally transferred from the acute hospital. Such 'safety values' have existed since the beginning of the National Health Services and before. In some community hospitals, there are 'elderly consultant beds', which provide rehabilitation for patients discharge from the acute hospital. Other widely available services include rehabilitation, physiotherapy, chiropody, speech therapy, convalescence, discharge planning, visiting consultant outpatient care, minor casualty services, direct access services and minor surgery.

5.3 Evaluations of intermediate care schemes

At present there are few evaluations of intermediate care schemes because of their recent rapid development.

5.3.1 Admission avoidance care schemes

For admission-avoidance schemes, the newest of the intermediate care schemes, there is just one descriptive preliminary report for rapid response services, which focus on organisation and process rather than on patient outcomes (Turner and Bray, 1999). On the other hand, there is a more substantial literature on nurse-led telephone triage (Dale, Crouch and Lloyd, 1998; Gallagher, Huddart, and Henderson, 1998), although it is also descriptive and centred on the organisation rather than the patient. An exceptional study carried out a randomised and controlled trial (RCT) of one GP cooperative's nurse administered telephone consultation service (N=14,492 calls through a year). Its results indicate that substantial reductions in GP contacts were not associated with an increase in adverse events, namely emergency hospital admissions within 24 hours and within 3 days of contact, and deaths within 7 days of contact (Lattimer *et al.*, 1998).

5.3.2 Post-acute care schemes

Compared with other kinds of intermediate care schemes, supported early-discharge schemes have been widely studied. Three systematic reviews of schemes for older, frail or chronically-ill patients have reported (Dunn, 1996; Bours *et al.*, 1998; Hyde *et al.*, 2000). Dunn's review of post-hospital discharge schemes in England and Wales during 1985-95 examined eight interventions and found that one was effective, four had equivocal results, and for three there were no significant differences between the intervention and control groups.

Bours and co-workers' review included 17 articles published during 1981-95 in the English, French, and Dutch-languages. Only three had an approved methodology. The review indicated that 57% of examined outcomes, including medical consumption, quality-of-life, quality-of-care, compliance and costs, presented no difference between the intervention and control groups. Hyde *et al.* (2000) reviewed nine 'randomised or quasi-randomised' controlled studies published up to 1997, and found that supported discharge from hospitals was strongly associated with a high proportion of patients living at home for 6-12 months after hospital admission in comparison to patients who received the usual hospital care. The intervention group was less likely to be institutionalised than the control group, and there was no difference in mortality. The findings about hospital readmissions during the follow-up period were more varied. For instance, four studies indicated beneficial effects of supported discharge, two found the opposite outcomes, and two found no difference between the intervention and control groups.

In contrast, the systematic review by Shepperd and Iliffe (1998) claimed that only five studies met standard methodological criteria for inclusion and therefore there was inadequate evidence to support extensive implementation. Two studies that compared hospital-at-home to ordinary hospital post-acute care indicated no significant differences in outcomes between two groups (Shepperd *et al.*, 1998a; 1998b). With particular reference to hip-replacement patients, a hospital-at-home scheme produced advantages in quality of life and much more involvement of the patients in decisions related to the care. As for cost effectiveness, both studies found no difference between intervention and control groups, while Coast *et al.* (1998) concluded that the mean cost of hospital-at-home care was significantly less than that of conventional post-acute treatment.

Finally, a very recent review (Cameron *et al.*, 2000) of six studies of post-fracture early supported-discharge found that the intervention reduced the stay in hospital and that there was a statistically insignificant increase in readmission rates. Additionally, the intervention group was more likely to return to their own home. Consequently it was concluded that the scheme led to cost-savings for the health and social services.

While there are various studies of hospital-at-home schemes, few on nursing unit schemes have been carried out. The literature reviews by Steiner (1997) and by Griffiths and Wilson-Barnett (1998) indicate that randomised controlled studies, on one therapeutic nursing unit in the United States and on two British nursing development units, identified important advantages for nurse-led care. The studies had, however, many methodological limitations, such as small sample size, biased control groups, failure to adjust for differences between intervention and comparison groups, and no clear evidence about effectiveness were consequently available.

The latest randomised controlled study avoided many of the previous methodological faults (Griffiths *et al.*, 2000). It found no significant differences between the nurse-led unit (NLU) patient group and a control group in functional independence at discharge, discharge destination or in-patient mortality. On the other hand, NLU patients had more inpatient deaths than control group patients, while more control group patients than NLU patients were discharged to nursing homes. Additionally, the duration of the care episode was significantly different between the two groups and longer for the NLU patients. Since length of stay is the key driver of costs, this model of care may be more expensive (Griffiths *et al.*, 2001)

5.3.3 Implications for services and research of current evidence

Intermediate care is likely to have a high priority for some time, in the pursuit of 'efficiency' of the NHS care system (particularly acute hospitals), and growing care needs. Innovative 'joint working between health and social services' has been energetically promoted to save public expenditure through avoiding duplication.

Although intermediate care schemes have been rapidly established throughout the country, little attention has been paid to their quality and efficiency. The initiatives that have been most successful have usually been dependent on the initiative of an individual rather than the result of a wider strategic initiative (Vaughan and Lathlean, 1999). As a result, there is immense diversity in the available range of care services even within single regions. They have variously involved statutory bodies, different budgets and contrasting locations, ways of access to services, eligibility criteria, and staffing levels.

There are increasing public and government concerns about the insufficient evidence available to answer the questions of whether the new services bring benefits to frail older people or, alternatively, may hinder their access to appropriate diagnostic or therapeutic hospital care. There is revived concern about the return of the ethos of the workhouse wards and their deficiencies (diagnostic failure, inadequate treatment and rehabilitation, long stays, and iatrogenic complications) (Ebrahim, 2001). There is also growing concern that the new care schemes less meet the care needs of frail older people than serve the goal of reducing the costs of care. Moreover, there is increasing concern that staff are unwilling to change their traditional working practice.

As yet there is insufficient evidence whether these new care schemes are cheaper than traditional care services, while their cost-effectiveness remains no more than a question of great interest to the government. There has been little consideration of whether home-based intermediate care services are acceptable to informal carers. The extra burden and responsibility produced by discharging patients 'sicker and quicker' from hospitals may give informal carers intolerable stress.

The meta-review mentioned above has shown that the published evidence presents conflicting reports of advantage and disadvantage alongside substantial uncertainty (with both beneficial and unfavourable effects). The inconsistent results may be caused by the complexity and variability of the interventions or by the poor methodological standards of the evaluations. Most evaluation studies of intermediate care schemes have examined rehabilitative care schemes which aim to help early discharge from hospital, and most describe the organisation of the services rather than patients' outcomes.

Overall, the current evidence about intermediate care services is too fragmentary and weak to support general conclusions or to feed back into new service provision. More research and evaluation are therefore needed. The optimal scale or nature of service provision requires further investigation. As a result, there is high demanding on national wide evaluation studies, which may answer the questions discussed above. In particular, the demanding areas of the studies are on patients' outcomes (physical ability and psychological wellbeing); services outcomes (readmission rate to hospital and admission rate to long-term facilities); satisfaction of service users and informal carers; staff' appraisal about the new working way; cost effectiveness and the impacts of multi-disciplinary team approach on service users. At the same time, local evaluation studies on intermediate care schemes should be also carried out due to geographical variance.

Section III

Empirical evaluation study of hospital avoidance scheme for older people with acute illness

Chapter 6

The study area and scope of the multi-strand evaluation

The last chapter reviewed intermediate care in the UK and showed that there is very little research evidence about its effectiveness. While most previous studies on intermediate care schemes have focussed on rehabilitative care schemes and those which aim to help early discharge from hospital, but there is scarce evidence of the effectiveness of hospital avoidance schemes. It was therefore decided that one of the most important current care service innovations in Britain for older people are the new intermediate care schemes. This research study evaluates one such scheme. At the time this research began in December 2000, a new Rapid Response Service (RRS) was being introduced in Barnsley. Furthermore, Barnsley is close to Sheffield and the Sheffield Institute for Studies on Ageing (SISA) has links through Professor Stuart Parker to the local agencies and services. The Barnsley RRS was therefore selected for the research evaluation.

Later, a national evaluation study of the costs and outcomes of intermediate care services for older people has been commissioned by the Department of Health and is being carried out by Nuffield Community Care Studies Unit, University of Leicester, in collaboration with the Departments of General Practice and Psychiatry for the Elderly (University of Leicester), the Sheffield Institute for Studies on Ageing, and the University of Birmingham. Nonetheless, intermediate care schemes are geographically very variable and it will take a considerable time to complete the national evaluation study.

This chapter describes the town of Barnsley and its older people services, the background to the research interest and the development of the Barnsley Rapid Response Service. The scope of the multi-strand evaluation of the local hospital avoidance scheme is then described.

6.1 The town of Barnsley and its older people services

Barnsley is a medium-sized town of 218,100 people in South Yorkshire. It was a major centre of coal-mining until 20 years ago, and also has diverse engineering employment. It is still dominantly a working-class town, and partly became of its industrial history, it has exceptionally high standard mortality rates, and high rates of chronic diseases in the older population.

There is one acute hospital in the town, the Barnsley District General Hospital which has three geriatric medicine wards (integrated with general medicine wards) and four other available wards for older people and about 260 beds for older people out of 600. There is one community hospital (Mount Vernon Hospital) which from 2002 has been managed by the primary care trust (PCT) and which provides in-patient stroke and rehabilitation care and sub-acute care services. The Barnsley PCT provides in-patient and community based services[1] for all age groups but particularly for children, older people, mentally-ill people, those with learning disabilities and physically-disabled people. Barnsley is a unitary Borough Council and therefore provides social services. 60 residential and nursing care homes are available for older people (2017 beds) (Warnes *et al.*, 2002). Six resource centres which used be residential care-homes operated by Social Services now provide diverse care services: rehabilitation, recuperation, day care, respite care, and intermediate care.*

No provision had been made in the town for 24 hour emergency response to provide acute nursing care and social support in the older patient's own homes, and therefore hospital admission was the only option. Meanwhile, the evidence that unnecessary hospital admissions can have a detrimental effect on the older person's ability to return to independence was also putting pressure on the acute services (Barnsley Health Authority and Social Services, 2000). An evaluation of the quality and performance of the NHS (NHS Executive, 2000b) found that Barnsley had the second highest rate of hospital emergency admissions of older people among 100 Health Authorities in England, as well as a very high rate of admission of those aged 75 years. For example, the rate was 288.5 per 1,000 population during 1998/99 compared with the average for England of 268 (Barnsley Health Authority, 2000). It was partly to meet these morbidity levels and service deficiencies that the Rapid Response Team Service was established on 11th December 2000.

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[1] Include district nursing, health visiting, school nursing, community psychiatric nurses, chiropody, occupational therapy, physiotherapy, speech and language therapy, and specialist services such as child health services, Macmillan nurses, continence advice, diabetic liaison service, family planning service, community dental service, psychology, child and adolescent mental illness, and substance misuse. These services are provided from health centres, clinics or GP surgeries. There are twenty-one health centres and clinics located throughout the district.

* The information in this paragraph is from direct or phone-interview of relative staff and web sites of Barnsley NHS (http://www.barnsley.nhs.uk/home.asp) and Barnsly Metropolitan Borough Council (http://www.barnsley.gov.uk).

The Barnsley Rapid Response Service

The Barnsley RRS provides a 24 hour facility for assessment and implementation of a care package, in close working connection with GPs, in the patient's own home, local authority resource centre or nursing home, to reduce the rate of older people's admission to hospital. The established criteria for referral are the patient would otherwise be admitted to hospital and the patient's own GP should accept medical responsibility as well. The patient should be more than 60 years old and be resident in the Borough of Barnsley. Additionally, the patient should agree to the care plan instead of ordinary hospital care. The team is based at Mount Vernon Hospital and consists of a Nurse G grade team leader, E grade RGN, B grade support workers, physiotherapist, occupational therapist (joined the team in August 2001), clerical support and social worker (joined to the team in November 2001).

In order to cope with the winter's pressures and to be a practical part of the winter plan, the team mainly plan to accept the referrals of patients with certain conditions, such as chest infections, reduced mobility and falls. In the plan of the Barnsley RRS, care is available only for a certain period of time until the acute phase of an acute illness is over or until a course of treatment is completed. The team plans to achieve an assessment within two hours of receiving a referral and to work closely with the referrer to set a proper care plan.

6.2 The scope of the multi-strand evaluation

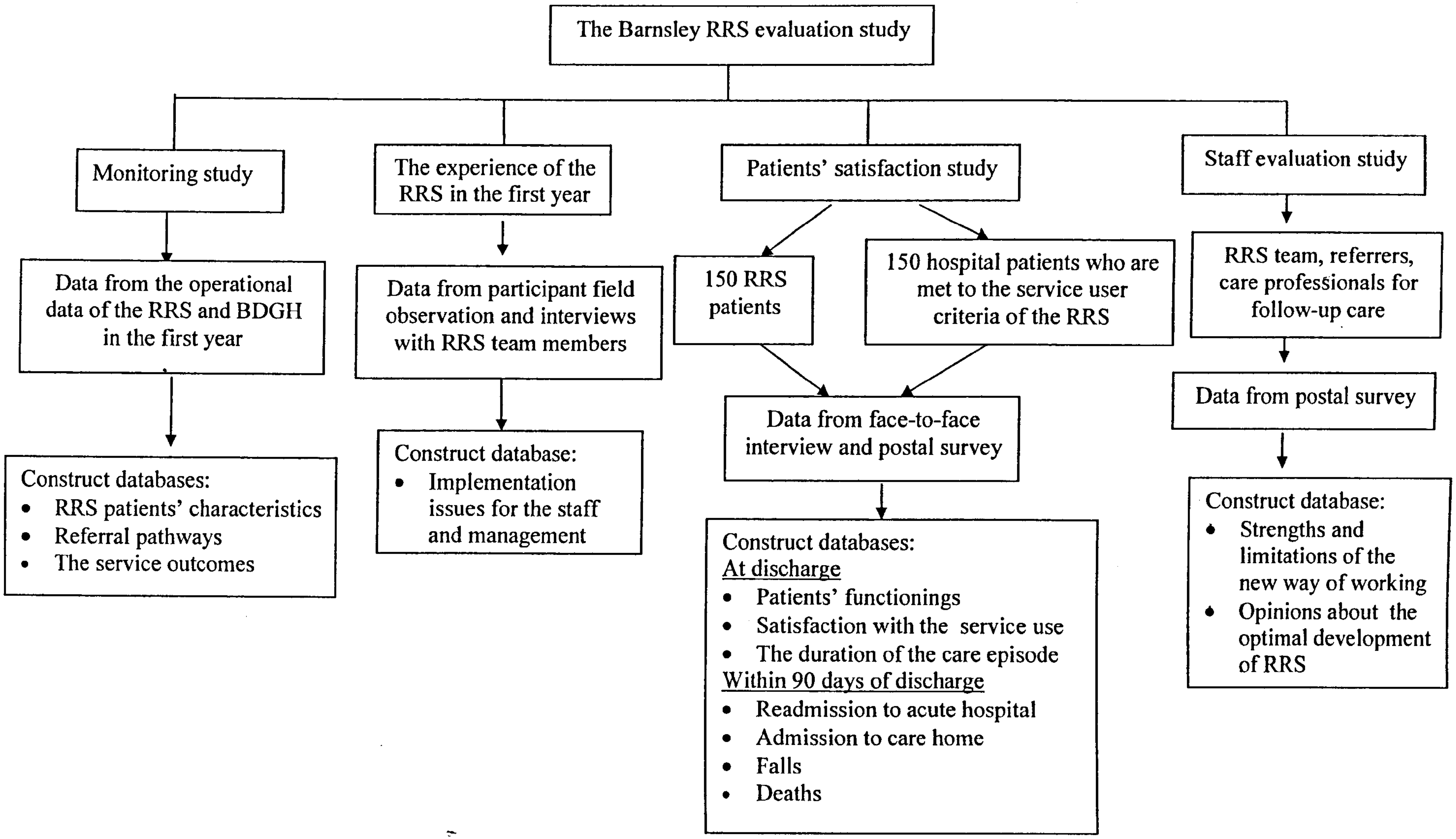
It was decided to undertake for the evaluation of the RRS a set of complementary studies with several connected and overlapping objectives, including to provide quantitative evidence on the performance of the RRS and the objective outcomes for the patients, but also to provide insights into the process of introducing and implementing a radically new kind of service – as seen by both the patient and the staff. The evaluation study had four component elements as shown on Figure 6.1: the monitoring study; the experience of the RRS in the first year; the patients' satisfaction evaluation study; the staff evaluation study.

The formal aims, design, methodology and execution of the various elements of the evaluation studies are dealt with in Chapter 7 to 10. The first part of study, the monitoring study, explores the RRS patients' characteristics, referral pathways and the service outcomes through analysing the routine operational data of the RRS and Barnsley District General Hospital. The study of the experience of the RRS in the first year by participant field observation and interviewing the RRS team members examines implementation issues.

The patient' evaluation study was undertaken using the face-to-face interviews and a postal survey, with comparisons between the RRS patients and matched hospital patients about functioning, satisfaction with the care service, the duration of the care episodes at discharge, readmissions to acute hospital, admission to care homes, falls, and deaths within 90 days of RRS or hospital care.

The staff evaluation study was undertaken by a postal survey of the staff who are involved in the RRS, including the team itself, referrers, and care professionals who provided for follow-up care. This evaluation explores the strengths and limitations of the new way of working, the new joint working arrangements between the health and social services and the primary, secondary community sectors of health care. The opinions of the various care professionals about the optimal development of the service are reviewed. The following figure presents the design of the multi-strand empirical evaluation study.

Figure 6.1. The design of multi-strand evaluation



Chapter 7

The monitoring study: patients' characteristics, referral pathways and the service outcomes of RRS

Since the first 'Emergency Response Service' was established in Milton Keynes in June 1996, many similar schemes have been established throughout the UK (Vaughan and Lathlean, 1999). However, the care schemes are all slightly different. For example, some emergency schemes are for older people and some for the entire population. Some are for only people with social problems and some for only those with acute illnesses. Staffing levels and composition, the number of places, access to schemes, available service time, and the offered services also differ by the region. Evidence of the limitations and experience of similar services in other regions has informed the development of the Barnsley Rapid Response Scheme (RRS). When the research began, however, there was little evidence about local hospital avoidance schemes of which the RRS is an example. The main aim of this study was therefore to establish and analyse the characteristics of referred patients, referral pathways, the performance of the RRS, the outcomes of service in the first year, and the destination of the RRS patients on 90 days after discharge. The main sources have been the RRS operational data and District General Hospital patient data.

This chapter begins by stating the primary research questions, and it then considers methodological issues and sets out the study design. The strategies for the data collection and analysis are then outlined, and finally the results are presented and discussed.

Research questions

a) What characteristics of older patients were referred to RRS, in terms of age group, marital status, living arrangements, dependency in personal care, feeding, continence, mobility, nursing, and psychological health, and the availability of informal and formal caregivers?
b) What referral pathways were established in the first year?
c) What did the RRS perform and achieve in the first year?
d) What proportions of RRS patients were admitted to hospitals and care homes and had died at 90 days from discharge?

7.1 Study design

This section will first describe the participants of this study. The types of study design and data collection methods will then be discussed. It describes the rational for the chosen methods and their strengths and weaknesses. The procedure of data collection and implementation issue will be described. Finally, ethical issues and the strategies for data analysis will be discussed.

7.1.1 Participants, research design and methods

All people referred to the RRS in the first year (12 December 2000 to 11 December 2001) were included in this study. Mixed quantitative and qualitative research methods were adopted. Investigators from both positivist and phenomenological perspectives have criticised the use of secondary data (documents) because the data are collected for other purposes and can lead to bias (Bowling, 2002). Nevertheless, there are many advantages in the use of secondary data as a source, such as their independence from the investigator, large sample sizes, convenience and low cost. The patients' notes, staff diaries and reports, and the hospital operational database provide the foundation for this account of the RRS's achievement in its first year. The principal sources for the characteristics of the patients and the referral were the RRS patient records, and the staff diaries and reports. Information on the RRS patients' admissions to hospitals or care homes and the death rate after discharge was collected from the Barnsley District General Hospital (BDGH) operational database.

7.1.2 Procedure of data collection and implementation

Phase 1: Collection of referral, performance and achievement data from routine operational records

Referrals were routinely on a referral or registration form. The characteristics and referral pathways of all referrals in the first year (12 December 2000 to 11 December 2001) were collected from these forms. Performance and achievement data of the RRS were then collected from the RRS patients' records.

Phase 2: Collection of service outcomes 90 days after discharge

For all patients who had been admitted to the RRS in the first year of the RRS, the hospital operational database was searched to discover their discharge destination other than own home (hospital, care home, or died) on 90 days of discharge.

Implementation issue

One of the main difficulties of collecting information for this study was persistent disagreements between management and staff on the completion of the operational records. Some useful information was sometimes omitted, some patient records went missing at the patients' home, and some papers were kept haphazardly. In particular, information about the referred patients who were not accepted by the RRS was often missing. Moreover, different assessment and record forms were being used concurrently. To reduce the quantity of missing data, the manager agreed to request the RRS team to record and manage the patient documents more fully and consistently. Although it took considerable time, the management of the patient records has greatly improved. The researcher is most grateful to the RRS team who made great efforts on my behalf in the first year.

7.1.3 Ethical issues

The principal ethical consideration in this study was to maintain the confidentiality of the personal data. An anonymous identify number was allocated to each participant, and their name was not entered into the research database. The national data protection legislation and the research conduct policies of the University of Sheffield were upheld, and due regard given to the legal and ethical requirements to maintain data safety and confidentiality. The study was approved by the Barnsley NHS Local Ethics Committees (Appendix 5).

7.1.4 Strategies for data analysis

The aims of the data analysis were to provide answers to the four research questions mentioned earlier. The rationale for using particular statistical tests with brief descriptions of each test are explained in Section 10.4.1. The rationale for the selection of statistical tests for the monitoring study will therefore be omitted to avoid duplication.

7.2 Main results

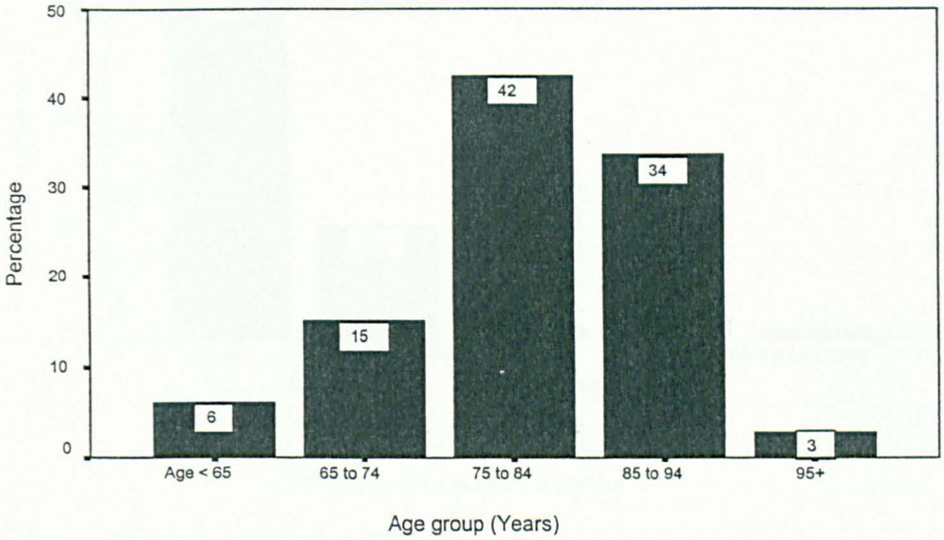
The main findings from the secondary data analysis will now be outlined under four headings (characteristics of referred patients, referral pathways, performance and achievement of the RRS, and after discharge from the care scheme). 556 referred people and 428 admitted RRS patients were included.

7.2.1 Characteristics of referred people

Sex and age group

556 patients were referred to the RRS between 12 December 2000 and 11 December 2001. Of these, 65 % (n=351) were female, while 35 % (n=192) were male. Patients aged 75-84 years (n=214) were the most numerous, followed by those aged 85-94 years (n=169) (Figure 4.2.1).

Figure 7.2.1 Patients referred to the RRS by age group, 2001 (n=556)



Marital status and living arrangements

Amongst the 556 patients referred to the RRS, the majority (64.4%, n=284) were widowed while 24% (n=107), 7.9% (n=35), and 3.4% (n=15) were married, single and divorced respectively (Table 4.2.1). The marital status of a relatively high number (115) was not recorded.

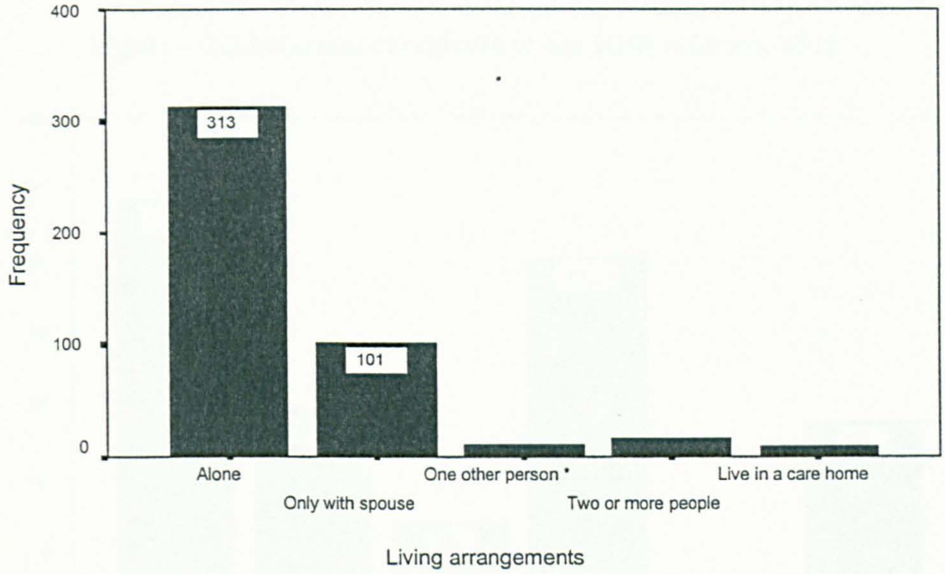
Table 7.2.1 Marital status

Marital status	Frequency	Valid percentage
Married	107	24.3
Single	35	7.9
Divorced	15	3.4
Widowed	284	64.4
Total	441	100.0

Notes: Total n=556; Missing n=115

Amongst 422 patients referred to RRS with the requisite information, 70% (n=313) lived alone, while 28.2% (n=101) lived with a spouse or others and 1.8% (n=8) lived in a care home (Figure 7.2.2). Clearly, the patients included a large number of widowed women who lived alone.

Figure 7.2.2 Living arrangements (n=556; missing n=109)



* who is not a spouse or partner

Dependency of patients referred to RRS

The dependency scale used by primary and community health care professionals in Barnsley assesses six dimensions of personal functioning and care: personal hygiene and care, feeding, continence, mobility, nursing, and psychological health. As shown below, the majority of the patients referred to RRS were independent in eating, continent and psychologically they were mildly dependent. They were also relatively dependent in personal care, mobility and nursing care (Table 7.2.2).

Table 7.2.2 Dependency scale of RRS referred cases

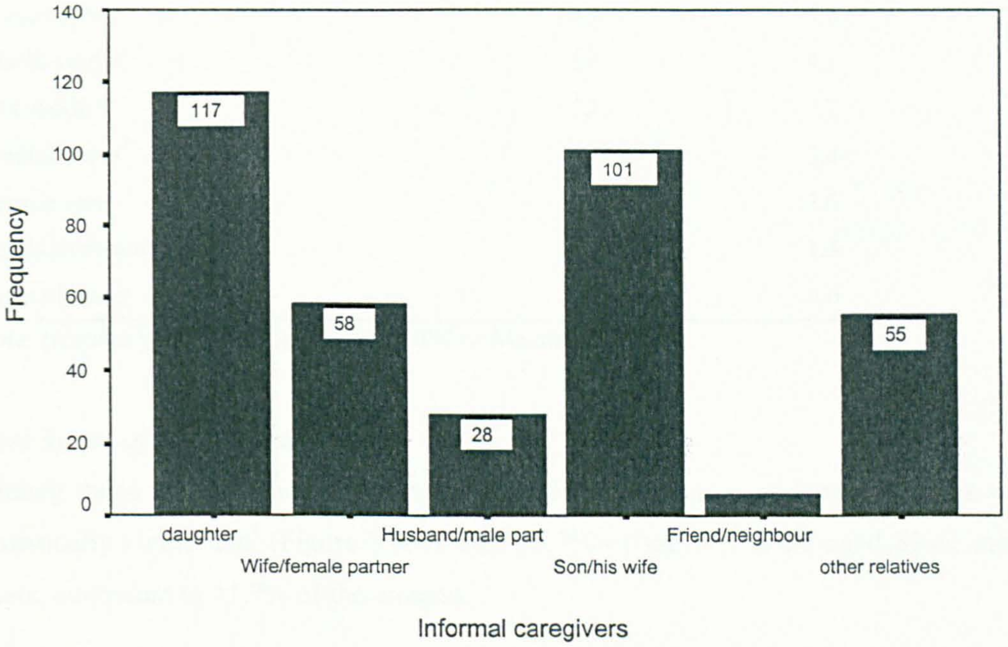
Dependency scale	Personal care n (%)	Feeding n (%)	Continence n (%)	Mobility n (%)	Nursing n (%)	Psychological Health n (%)
Independent	37 (12.5)	88 (29.9)	107 (36.4)	34 (11.6)	34 (11.6)	76 (25.9)
Low	34 (11.5)	76 (25.9)	71 (24.1)	42 (14.3)	94 (32.0)	93 (31.6)
Medium	83 (28.1)	69 (23.5)	58 (19.7)	87 (29.6)	78 (26.5)	60 (20.4)
High	76 (25.8)	30 (10.2)	30 (10.2)	79 (26.9)	59 (20.1)	32 (10.9)
Dependent	65 (22.0)	31 (10.5)	28 (9.5)	52 (17.7)	29 (9.9)	33 (11.2)

Note: Total sample was 556 but the data for 262 patients were missing

Availability of informal and formal caregivers

Amongst 436 people referred to the RRS with the requisite information, 84.4 % (n=369) had informal carers and 15.3% (n=67) no informal caregiver. Of the informal caregivers, 27%, 23%, 20%, and 14% were respectively daughters, sons or their wives, spouse or partner, and friends or other relatives (Figure 7.2.3).

Figure 7.2.3 Informal caregivers of the RRS referees, 2001



Notes: n=556; no informal caregiver=67; missing n=124

The health and social care services which were being used most frequently by the people referred to RRS were home (social) care (30.6%), the community health district nursing service (29.4%), day care (12.5%), privately paid home help (11.6%), the 'aids and adaptations' services of social services (8.8%), and the 'central alarm call' or an equivalent warden service (7.9%) (Table 7.2.3).

Table 7.2.3 Use of health and social care services by the referees

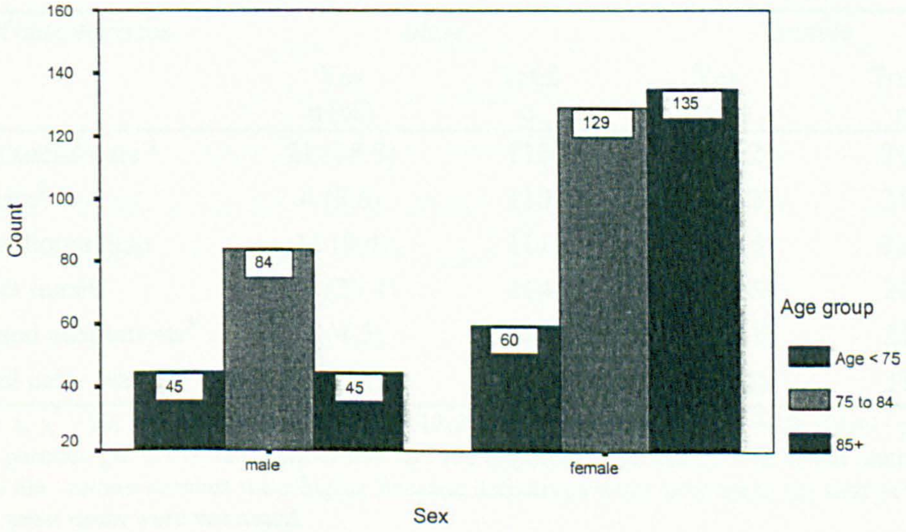
Care services	n	%
Home social care	102	30.6
District nursing care	99	29.4
Day care	41	12.5
Private home help	38	11.6
Aids and adaptations	29	8.8
Central-call or warden service	26	7.9
Meals-on-wheels	17	5.2
Home loans	15	4.6
Health visitor	14	4.3
Chiropodist	12	3.7
Special nurse*	11	3.4
Respite care	10	3.0
Neighbourhood support	5	1.5
Physiotherapy	2	0.6

Note: Includes private sector services, CPN or Macmillan nurse

Ages by sex of the referred people

Among those referred, the men were younger than the women, and the difference was statistically significant[1] (Figure 7.2.4). Just 25.7% of the men were aged 85 or more years, compared to 41.7% of the women.

Figure 7.2.4 Patients' referrals by age group and sex (n=556)



Note: missing n=56

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[1] (x^2 =12.6; d.f.=2; p=0.002)

The relationship between marital status and sex

There was a significant association between marital status and the sex of the people referred. Men were more likely to be married, while women were more likely to be widowed or single (Table 7.2.4).

Table 7.2.4 The association between marital status and sex

Marital status	Sex		
	Male n (%)	Female n (%)	Total n (%)
Married	67 (44.7)	40 (13.9)	107 (24.4)
Single, divorced or widowed	83 (55.3)	248 (86.1)	331 (75.6)
Total	150 (100)	288 (100)	438 (100)

Notes: Missing cases n=118; Chi-squared test was used to explore the association between the categorical variables (χ^2 =56.9; d.f.=3; p<0.001)

The relationship between the use of care services and sex

Home care services (home social care, day care, home private help, district nurse service, aids and adaptations service, and central care or warden services) were more frequently used by women than men. The chi-squared statistics show that there were significant associations between the referred patient's sex and their use of home social care, day care, and aids and adaptation service (Table 7.2.5).

Table 7.2.5 The use of care services by sex

Use of care services	Male		Female	
	Yes n (%)	Total n	Yes n (%)	Total n
Home social care [1]	21 (18.8)	112	79 (36.2)	218
Day care[2]	4 (3.6)	110	37 (17.2)	215
Private home help	11 (9.9)	111	27 (12.6)	214
District nurse	29 (25.4)	114	70 (31.5)	222
Aids and adaptations[3]	5 (4.5)	112	24 (11.1)	217
Central call / warden	7 (6.3)	112	18 (8.4)	215

Notes: 1. χ^2 =10.7; d.f.=1; p=0.001; 2. χ^2 =12.2; d.f.=1; p=0.0001; 3. χ^2 =4.0; d.f.=1; p=0.046; The percentages are of the number that had the requisite information. The actual numbers that used the various services were higher because defective record keeping in the first year meant that some users were not noted.

The relationship between living arrangements and sex

There was a significant association between living arrangements and the sex of the referrals. 80.8% of female referrals (n=235) lived alone but only 49.0% of male referrals (n=75). 42.5% of male referrals (n=65) lived with a spouse or partner but only 12.4% of female referrals (n=36) (Table 7.2.6).

Table 7.2.6 Living arrangements by sex

Living arrangement	Sex		Total
	Male	Female	
Alone	75 (49.0)	235 (80.8)	310 (69.8)
Only with spouse or partner	65 (42.5)	36 (12.4)	101 (22.7)
With only one other person*	5 (3.3)	5 (1.7)	10 (2.3)
With two or more others	7 (4.6)	8 (2.7)	15 (3.4)
Residential or nursing home	1 (0.6)	7 (2.4)	8 (1.8)
Total	153 (100)	291 (100)	444 (100)

Notes: * not a spouse or partner; Test statistics: χ^2 =58.2; d.f.=4; p=0.001

The relationship between living arrangements and the availability of formal or informal carers

There was a significant association between living arrangements and the use of paid carers as expected[2]. People with a paid carer were more likely to live alone than people without. On the other hand, people who had no paid carer were more likely to live with spouse, partner, or others people than people with a paid carer.

There was a significant association between the living arrangement and the availability of an informal carer. People who lived with a spouse were more likely to have an informal carer than than people without and, of course, most often the spouse was the carer. On the other hand, people without an informal carer were more likely to live alone. However, patients with an informal carer were less likely to live with others, not their spouse or partner, than patients without (Table 7.2.7).

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[2] (χ^2 =9.8; d.f.=2; p=0.007).

Table 7.2.7 The association between living arrangements and having an informal carer (n=556)

Living arrangements	Availability of informal carer		Total
	Yes n (%)	No n (%)	
Alone	239 (66.8)	56 (88.9)	295
With spouse or partner	98 (27.4)	3 (4.8)	101
With other people*	21 (5.9)	4 (6.3)	25
Total	358 .	63	421

Notes: * not spouse or partner; Missing n=124; 11 patients lived in a care home were excluded; Test statistics; χ^2 =9.8; d.f.=2; p=0.001

7.2.2 Referral pathways

This section aims to describe the 'pathways' by which older patients with acute illness were referred to the RRS, using the RRS operational data on assessment and admissions. It describes the reasons for and the consistency of the patient referrals, and the distribution of referrers in the first year. The trends over time in the pattern of referrals and refusals are analysed.

The problems of people referred to RRS

As shown in Table 7.2.8, the most frequent main problem of the patients referred to the RRS were injuries or with mobility following falls. Next in frequency came respiratory problems, such as chest infection, chronic obstructive pulmonary disease (COPD), asthma, TB or lung cancer. The most frequent second reason for the patients' referrals was the need for support, and this was followed by being 'generally unwell' or having reduced mobility (Table 7.2.9).

Table 7.2.8 The first reason for the RRS patients' referrals (N=556)

Main Reasons	n	%
Injury or mobility problem following a fall	134	25.4
Chest infection, COPD, asthma, TB or lung cancer	86	16.3
General deterioration or reduced mobility[1]	57	10.8
CVA extension or TIA	37	7.0
Gastro-intestinal problem[2]	35	6.7
Pain in knee, leg, hip or back[3]	26	4.9
Deteriorated confusion, depression or dementia	21	4.0
Cellullitis on legs	21	4.0
No formal or informal caregivers but need of support	20	3.8
Changed formal or informal caregivers' circumstances[4]	20	3.8
Terminal illness for palliative care	15	2.8
Urinary tract infection or renal problem	13	2.5
Diabetes for BM, ulcer care on foot, or insulin therapy	9	1.7
Heart failure or angina	6	1.1
Other problems[5]	28	5.3

Notes: Total n=556; missing n=28; 1. Includes deteriorated Parkinson's disease; 2. Includes infection, diarrhoea, constipation, vomiting, or problem with colostomy; 3. Includes pain from osteoporosis; 4. Includes informal caregiver's illness, ceased formal care, or informal caregiver's holiday; 5. Includes hypertension, DVT, shingles, burn, assessment for hip, problem with morphine syringe-driver commencement or gastric-tube feeding, swallowing difficulty, medication advice, anaemia. Abbreviations: CVA (Cerebro-vascular accident), TIA (Transient ischaemic attack), COPD (Chronic obstructive pulmonary disease, TB (Tuberculosis), BM (Blood glucose monitoring).

Table 7.2.9 Three most prevalent second reasons for the patients' referrals

Second reason	n	%
No formal or informal caregivers but need of support	198	43.5
General deterioration or reduced mobility,	88	19.3
Changed formal or informal caregivers' circumstances*	43	9.5

Notes: Total n= 556; missing n=101; *includes informal caregiver's illness, ceased formal care, or informal caregiver's holiday

Referrers and referrals for the first year

In the first year of the RRS, 55.2% (n=303) of the referrals were by general practitioners (GPs), and 32.2% (n=177) by staff in A&E and the admission ward of BDGH. Of the remainder, respectively, 4.6% (n=25), 4.4% (n=24), 2.9% (n=16), and 0.7% (n=4) were referred by social workers, primary health care staff (district nurse or special community nurse), a health call (GP consultation service at night), and by themselves (self-referrals) (Table 7.2.10).

Table 7.2.10 Referrals by agencies or profession

Agency or professionals	n	%
General medical practitioners	303	55.2
Hospital staff (A&E / admission ward etc)	177	32.2
Social workers	25	4.6
Primary health care staff (district nurse / special nurse etc)	24	4.4
Health calls	16	2.9
Patients' self-referrals	4	0.7
Total	549	100.0

Notes: Total sample size=556; Missing n=7

To examine the trends in the referral patterns during the first year of the RRS, the year has been divided into quarters. As shown on Table 7.2.11, referrals increased from the first to the second quarter, decreased during the third, and increased again during the fourth quarter.

Table 7.2.11 Referrals by successive 3 month periods

Quarter of year	Frequency	Valid Percent
1. 12/12/2000 to 11/03/2001	128	23.1
2. 12/03/2001 to 11/06/2001	151	27.2
3. 12/06/2001 to 11/09/2001	123	22.2
4. 12/09/2001 to 11/12/2001	153	27.6

Notes: Total n=556; Missing n=1

More than three quarters (n=428; 77.0 %) of the 556 referrals were admitted to the RRS. 71.7 % (n=81) of the patients not admitted were refused by the RRS team, and the main reasons were: ineligibility, the required intervention or treatment was not available, or the patient needed care or a medical assessment before admission to the RRS. 6.2 % (n=7) were refused by the GP, and in 22.1% (n=25) of the cases, the patient (or a relative) declined (Table 7.2.12).

Table 7.2.12 The reasons for non-admission to the RRS

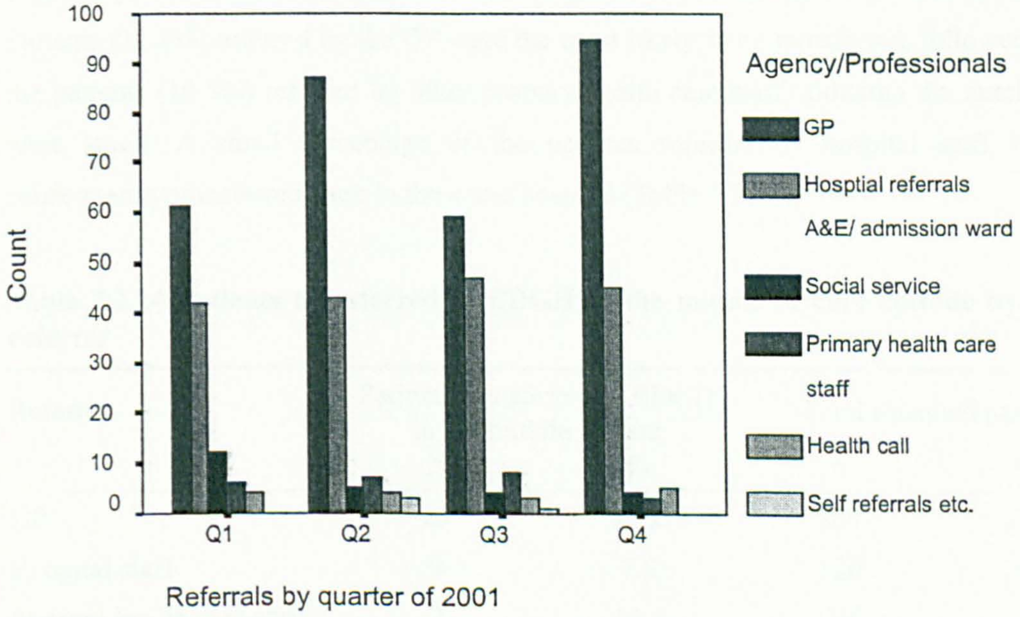
Reasons	n	%
GP refused to accept medical responsibility	7	6.2
Patient or relative refused	25	22.1
RRS team refused	68	60.2
a) Ineligible for RRS		
b) Intervention or treatment not available	10	8.8
c) Need for prior care or medical assessment	3	2.7
Total	113	100

Notes: Total n=128; Missing n=15; a) e.g. patients with chronic, social or mental problem or younger than 65 years; b) e.g. patients who need intravenous antibiotics or fluid therapy, patients with fracture, not available facility for oxygen therapy etc.

Referrals by the care professionals by quarter of 2001

The numbers of referrals by GPs fluctuated through the year, while the number of referrals by BDGH A&E and admission ward staff was relatively stable. In the first year, referrals by GPs gradually increased until June, decreased in the summer, and revived in the following winter. There was also a decline in the number of referrals by social workers, although the numbers throughout were few (Figure 7.2.5).

Figure 7.2.5 Referrals by different agencies or care professionals at time points



Notes: For dates of quarters, see Table 12; Total n=556; Missing n=1;
Test statistics: χ^2 =24.3; d.f.=15; p=0.061

Acceptance rates of different care professionals' referrals

Amongst the various referral pathways, all four self-referrals were accepted. Otherwise GPs' referrals had the highest acceptance rate (86%), followed by those made by primary health care professionals (79%). Referrals by social services staff and by health call staff (a GP consultation service at night) had the highest refusal rates (Table 7.2.13).

Table 7.2.13 Acceptance rates of different care professionals' referrals

Care professionals or source	Accepted		Not accepted		Total
	N	%	n	%	
GP	260	86.1	42	13.9	302
Hospital staff (A&E/admission ward)	120	67.8	57	32.2	177
Social services staff	15	62.5	9	37.5	24
Primary health care staff	19	79.2	5	20.8	24
'Health call' staff	10	62.5	6	37.5	16
Self-referrals	4	100	0	0	4
Total	428	77.0	128*	22.7	556*

Notes: * Includes missing n =9.

Patients transferred to the BDGH in the middle of care episode

9.6% of patients were transferred to acute hospitals in the middle of the care episode. Patients (11.2%) referred by the GP were the most likely to be transferred, followed by the patients (10.5%) referred by other primary health care staff, although the numbers were small. A small percentage of the patients referred by hospital staff were subsequently transferred back to the acute hospital (Table 7.2.14).

Table 7.2.14 Patients transferred to BDGH in the middle of care episode by the referrer

Referrer	Patients transferred to BDGH in the middle of care		Total accepted patients	
	N	%	n	%
GP	29	11.2	260	100
Hospital staff	9	7.5	120	100
Primary health care staff	2	10.5	19	100
Others[a]	1	10.0	29	100
Total	41	9.6	428	100

Note: a. Includes health call, social service, and self referrals

7.2.3 Performance and achievement of the RRS

This section reviews the performance of the RRS in the first year, largely by drawing on information from the operational data of the RRS. It describes the patients' placements for RRS care, and the involvement of care professionals within and beyond the RRS care team in the provision of care. The associations between patients' characteristics and both the care placements and the duration of the care episode are examined. This section concludes with a discussion of whether the RRS performed as an alternative to hospital care.

Patients' placements for care

65.4% of the patients were placed in either nursing or residential care homes (NRCH) or the resource centres operated by Barnsley Social Services for the RRS care episode. 37.1% (n=159) were placed in NRCH but 6.3% (n=10) of those were transferred to their own home during the care episode. 28.3% (n=121) of RRS patients were placed in the resource centre but 6.6% (n=8) of them were transferred to their own home while on the scheme. 34.6% (n=148) of the RRS patients received RRS care in their own homes (Table 7.2.15).

Table 7.2.15 Patients' placements for the RRS care

Patients' placements	n	%
Care in own home	148	34.6
Resource centre	113	26.4
Private sector nursing or residential care home	149	34.8
After staying at a resource centre, care in their own home	8	1.9
After staying at NRCH, care in their own home	10	2.3
Total	428	100

Involved care professionals within and beyond the RRS during care and follow up

The inaugural RRS team comprised one team leader (a G grade nurse), 4.5 full-time staff nurses (E-grade), a physiotherapist and support workers. A social worker and an occupational therapist joined the team in November 2001 and in August 2001 respectively. Before the social worker joined the scheme, patients were routinely referred to a social worker on discharge. Similarly, before the occupational therapist joined the team, patients were referred the community occupational therapist according to need. As shown in Table 7.2.16, the majority of patients were assessed and cared for by the nurse, social worker, physiotherapist and occupational therapist. Other care professionals beyond RRS were also involved in assessment or in providing care during or after care scheme according to need. The patient's own GP took responsibility for the patient's medical care.

Table 7.2.16 Combinations of care professionals within and beyond the RRS team involved during episode

Care professionals involved during or after RRS care scheme	n	%
Nurse and social worker	122	34.0
Nurse, social worker, physiotherapist, and occupational therapist	82	22.8
Nurse, social worker and physiotherapist	72	20.1
Nurse, social worker and district nurse	20	5.6
Nurse, social worker, physiotherapist, occupational therapist, and district nurse	17	4.7
Nurse, social worker, physiotherapist, and district nurse	15	4.2
Nurse, social worker and community psychiatric nurse	7	1.9
Nurse, social worker and occupational therapist	6	1.7
Nurse, social worker, occupational therapist, and district nurse	4	1.1
Nurse, social worker, occupational therapist, Community psychiatric nurse and district nurse	3	0.8
Nurse, social worker and hospital at home[a]	3	0.8
Other [b]	8	2.4
Total	359	100

Notes: Total n=428; Missing n=69; All patients' own GPs were involved in the RRS care scheme with agreement; Social worker from social service before November 2001; Social worker within RRS team after November 2001; Occupational therapist joined to RRS team in August 2001; Nurse and physiotherapist within the RRS team; the other care professionals, such as district nurse, community psychiatric nurse, and chiropodist are from the other agencies; a. operated by community health care services; b. There were in addition 8 care episodes involving nurses, social workers and 1 to 3 other care professionals.

As shown in the table above, a nurse and a social worker were involved in all the RRS care episodes, while physiotherapists and occupational therapists were involved in one-half and one-third respectively (Table 7.2.17).

Table 7.2.17 Involvement of individual care professionals in the RRS episodes

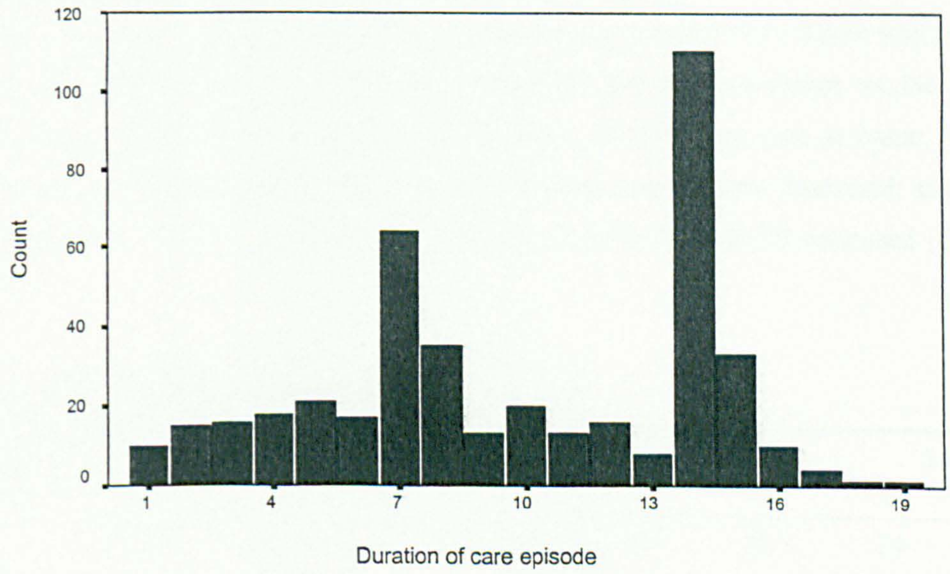
Care profession	Episodes (%)
Nurse	100
Social worker	100
Physiotherapist	51.8
Occupational therapist	31.2
District nurse	6.1
Community psychiatric nurse	2.8

Note: The percentages are of all RRS patient episodes in the first year.

Duration of the care episode

The patients who received care at their own home generally stayed on the care scheme for seven days, and most of those who received care at care homes or the resource centre did so for 14 days. The average duration of all care episodes was 9.9 days (median 10 days). The shortest stay was one day, and the largest 30 days (Figure 7.2.6).

Figure 7.2.6 Duration of care episode



Marital status, living arrangements and patients' placement

There was a significant association between a patient's marital status and their placement for care. Married patients were most likely to have care at home, and single and widowed patients more likely to have the care in either a resource centre or a nursing home. Nearly one half (47.6 %, n=40) of the patients living with a spouse or partner had the RRS care at home, compared to less than one fifth (17.4 %, n=4) of the patients living with others. Of the latter, 82.6 % (n=63) had the care either at the resource centre or in a nursing or residential care home. There was a significant association between the patients' living arrangements and the placement for care (Table 7.2.18).

Table 7.2.18 Patients' placements by living arrangement

Living arrangement	Care at own home		Resource centre		Nursing home (NRCH)		Total	
	n	%	N	%	n	%	n	%
With spouse / partner	40	47.6	9	10.7	35	41.7	84	100
With relative / friend(s)	4	17.4	10	43.5	9	39.1	23	100
Total	44	41.1	19	17.8	44	41.1	107	100

Notes: Total n=112; missing n= 5; Test statistics: χ^2 =15.0; d.f.=2; p=0.001

Age group, sex and the duration of the care episode

There was a small but statistically significant difference in the duration of stay on the care scheme between males and females. Male patients stayed on the scheme for an average of 9.3 days, while female patients for an average of 10.2 days. There was also a significant association between the age group and patients' placement on the care episode. 54.1 % (n=40) of patients aged less than 75 years had care at home. With increasing age, the proportion of the patients who had care at home decreased, and the proportion who received care at either a resource centre or a NRCH increased (Table 7.2.19).

Table 7.2.19 Patients' placement by the age group

Age group (years)	Care at home		Resource centre		NRCH		Total	
	n	%	N	%	n	%	n	%
< 75	40	54.1	15	20.3	19	25.7	74	100
75 to 84	60	35.5	41	24.3	68	40.2	169	100
85+	42	26.9	55	35.3	59	37.8	156	100
Total	142	35.6	111	27.8	146	36.6	399	100

Note: χ^2 =18.9; d.f.=4; p=0.001; NRCH: Nursing or residential care home

The patients' placement and the total dependency score

The range of the patients' total dependency score was between 6 and 30. The score 6 indicates independence in personal care, feeding, continence, mobility, and nursing care, and good psychological health. The scores 6-12, 13-18, 19-34 and 25-30 mean respectively low, medium, high, and very high dependency in the six dimensions of self-caring. The mean total dependency score of patients placed in their home was 14.8, while the mean total dependency score of patients placed either in a resource centre or in a care home was 17.8. There was a statistically significant difference in the total dependency score between the patients who had care at home and those who had care in either a resource centre or a nursing home.[3]

The patients' placement and their age

There was a statistically significant difference in age between the patients who received the care at home and those who had care in either a resource centre or a nursing home. Patients placed in a institution during the care scheme were 4.2 years older than patients placed at their own home.

7.2.4 After discharge from the care scheme

This section describes the readmissions to the local acute hospital (BDGH) within 7 days, 28 days, and 3 months of discharge from the care scheme. It also reviews the admissions to a care home as a permanent resident, and deaths within 3 months after discharge from the RRS care episode.

Readmission to hospital within 7 days, 28 days, and 3 months after discharge

Among the 428 patients admitted to the RRS care scheme for which there is information, 14.1 % (n=44), 20.5 % (n=63), and 32.2 % (n=98) were admitted to the local acute hospital within respectively 7 days, 28 days and 3 months of discharge from the RRS care episode (Table 7.2.20).

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[3] Patients placed in their home: Mean (s.d.)=14.8(5.6); patients placed either in a resource centre or in a care home: Mean (s.d.)=17.8 (5.6), *t* (267), p=0.0001, 95% CI=1.6-4.4.

Table 7.2.20 Readmission to hospital after discharge from the care scheme

Readmission	Yes	
	N	%
Within 7 days	44	14.1
Within 28 days	63	20.5
Within 3 months	98	32.2

Note: Total n=428; missing n=120. The frequencies are cumulative, so the 28 admitted within 28 days include the 7 admitted within seven days.

The proportion of RRS patients admitted to a care home as a permanent resident within 3 months of discharge from the RRS

Amongst 428 patients admitted to and discharged from the RRS care scheme, 10.5 % were admitted to a care home as a permanent resident within 3 months of discharge. Information about 85 patients was missing, and 37 patients who died within 3 months of discharge have been excluded.

The proportion of RRS patients died within 3 months of discharge

Among the patients discharged from the RRS care scheme and for whom there is information, 11.8 % (n=37) of those died within 3 months after discharge from the care scheme. Information about 115 patients is missing.

7.3 Discussion of findings

7.3.1 Characteristics of referred people

Among 556 people referred to the RRS in the first year, around two-thirds were women and the majority were aged 75-84 years. There were also many of greater age (85 to 94 years) and most of them lived alone (70%). The sex distribution of the referred people was similar to that of the very old population in South Yorkshire.[4] Women were significantly more likely to live alone than men, and they were significantly more likely to use formal care services, such as home, day care and aids and adaptation service. The sex distribution of the people referred to the RRS who lived alone was slightly different to that of older people in Great Britain. An important finding is that the referred patients to the RRS were much more likely to be living alone than the general population of similar age (Table 7.3). As previous studies have suggested that the probability of needing formal domiciliary help or care in a nursing / residential home is greater among people who live alone. It appears that the RRS meets the needs of older people who need support or care. As expected, most people had chronic illnesses or disabilities and were dependent in one or more of the personal care, mobility and nursing care functions.

Table 7.3 Aged 75 and over lived alone

	Aged 75 and over lived alone	
	Women	Men
Referred people to the RRS	86%	54%
Older population in Britain*	59%	29%

Source: *Office for National Statistics (2000)

7.3.2 Referral pathways

Most of the referred patients suffered from one or more chronic disorders at the time of an acute event. They were mostly referred by general practitioners (GPs) and by staff in A&E and the admission ward of BDGH. As is found in other care services, a strong seasonal pattern to the number of referrals was observed.

Of the referrals not admitted to the care scheme, 60% did not meet the service criteria. The proportion of referrals by different groups of health professionals that were accepted fluctuated over the year. In particular, the non-acceptance rate of hospital staff referrals gradually increased. Nevertheless, only a low percentage of referrals by hospital staff were transferred to the acute hospital in the middle of the care episode, while the patients referred by the GP were the most frequently transferred. Overall, the differential acceptance and transfer rates suggest that GP's recommendations carried more weight than those made by other health professionals but were less 'appropriate'. The statistical evidence suggests that GPs had a relatively high rate of referral of patients to the RRS who were too ill to be cared for by the team.

7.3.3 Performance and achievement of the RRS

The duration of the care episode was a function of the patients' placements and the scheme's capacities rather than the patient's needs. It should be remembered that the maximum permitted duration of RRS care was 7 days for patients' own home, and 14 days for care in a resource centre or NRCH. The limitation of the care episode was not for the benefit of the admitted service users but to maximise the number of people with a sub-acute need that the RRS could help, and thereby prevent hospital presentations

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[4] People referred to the RRS: (aged 80+ years women : men = 71: 29); 80+ years population in

and admissions. In these circumstances, there were inevitably a considerable number of RRS patients who needed more care or support at discharge. Their continuing needs had to be addressed.

Many different care professionals within and beyond the RRS team were involved in the assessment and care of the patients during the RRS episode and the follow-up. The RRS patients were contacted by numerous care professionals during the short RRS care episode. The involvement of multiple professionals in the short duration may indicate that the RRS provided intensive care and many interventions. As mentioned above, most people had chronic illnesses or disabilities and were dependent in one or more of the personal care, mobility and nursing care functions. It also supports that their needs would be straightforwardly dealt with the intensive and short care or intervention. Overall, these findings suggest that the RRS would be more dedicated to assess rapidly the patients to enable them to access to available care services.

Patients' placements for RRS care were associated with their marital status, living arrangements, age and dependency in self-caring. It was common for the informal caregiver to be closely involved in the care during the RRS episode.

Is the RRS a true alternative to hospital care, and does it duplicate existing community and primary health or (and) social services for older people?

One of the purposes of the RRS, as with other intermediate care schemes, is to prevent 'avoidable' hospital presentations and admissions. It has been claimed that 20% of hospital inpatient days for older patients in England and Wales are 'inappropriate' (National Health Service Executive, 2000). On the other hand, some literature about acute hospital admissions argues that the vast majority of acute hospital admissions are appropriate (Coase *et al.*, 1996). Older people who need rapid assessment for and access to community and primary health care and social services, or who need rehabilitation services, or who suffer rapid deterioration, may be among the 20% of alleged inappropriate admissions. There is no sharp break between acute and chronic health disorders. They have been often called 'bed blockers' in the acute hospital. Whichever inference is correct, it is essential that the care needs of those people should be met by appropriate care services through either acute hospital or innovative community-based care services.

South Yorkshire: (women: men=70: 30) (Warnes *et al.*, 2002).

This reality has led to the growth of interest in 'intermediate c are' schemes, although their definition and form vary (Steiner, 1997). There is also widespread interest in creating services that help avoid or reduce periods of hospitalization. In fact, the aim of the RRS, as defined by Barnsley Health Authority and Barnsley Social Services (2000) was to prevent admissions to hospital. Before the RRS was established, some patients who needed rapid assessment for and access to community, primary, social, or rehabilitation services would have been admitted to acute hospital beds.

As it has turned out, the RRS, has provided services to not only patients who would have been admitted to hospital, but also to many older people with a need for district nursing care, social care, support and respite care. The main reason for the use of the RRS by such 'unintended' patient groups may have been because the eligibility criteria patients were vague or inconsistently applied by the service providers and referrers. According to the Barnsley Health Authority and Social Services leaflet (2000), patients with COPD, asthma, cellulitis, DVT, chest infection, terminal care needs, mild CVA, transient ischaemia, and dehydration could be referred. In a report which described the RRS operational procedure (Barnsley Health Authority *et al.*, 2001), the eligibility criteria were:

- resident in the Borough of Barnsley
- aged 65 years or more
- have presenting needs which would otherwise required an admission to hospital have exercised an informed choice with respect to accessing the service
- have the potential to remain in the community after discharge from the RRS
- have a GP willing to retain medical responsibility.

The third criterion emphasises cure from medical illnesses, while the later criteria are too vague to apply in practice. The vagueness appears to have allowed the gap in understanding of the eligibility criteria between the service team and the referrers, which caused many and recurrent difficulties. They included inconsistent decisions on referrals, which in turn confused referrers about which patients to refer. More generally, it produced mutual misunderstanding between the service team and the referrers. The RRS team members by and large understood that the service was only for patients with acute medical problems, and the referrers were more likely to understand that the RRS should be for people with social or district nursing care needs with chronic illnesses or disabilities. However the referrers, especially GPs rarely referred patients with acute medical problems, because they believed that the RRS had inappropriate diagnostic and therapeutic capacities – a view expressed by MacMahon (2001). The RRS case load had many patients with social care or community nursing needs, and the RRS team believed that some patients with respite care needs were misusing the service. It remains unclear whether the RRS is truly an alternative to hospital care, because some its patients were diverted from, or properly clients of, district nursing or social care.

7.3.4 After discharge from the care scheme

It has been suggested that the rate of unplanned (re)admissions is an indicator of the quality of care (Victor and Jeffries, 1985). Others believe that high readmission rates are 'the price for shorter in-patient stay' (Jones 1985; Pearson et al., 2002). It is clear that the rate of (re)admission to hospital among RRS patients (19.6% within 28 days of discharge) was considerably higher than for Barnsley District General hospital patients (11.4% in 1998) or for hospital patients in other regions (15% Tierney and Worth, 1995; 13.2% Pearson et al., 2002). The high percentage of RRS patients being (re)admitted to hospital suggests that the needs of patients with acute medical care needs were not met during the care episode. The limited duration of care was also a factor in the high post-discharge hospital admission rate. On the other hand, it is possible that the RRS intervention produced positive or benign outcomes for most of its patients. The very fact of its rapid and relatively comprehensive assessment may have increased the awareness of local health care professionals, including GPs, to the patients' current condition, and brought forward hospital admissions or, from the patients' perspective, access to required treatment.

Chapter 8

Experience of the RRS in the first year

The RRS team members were required to work collaboratively not only with each other but also with other care professionals in the (then) Community Health Trust and in other agencies. Although joint working brought many advantages to the patients, the care professionals had never previously worked in this way and were unfamiliar with its requirements. There were teething and some recurrent problems in the implementation of the service. One aim of this study was to appraise the problems during the setting up phase. The evaluation of the experience of the RRS in the first year will have useful lesson for the establishment and development of other similar care services to the RRS.

8.1 Study design

This section first discusses the strengths and weaknesses of alternative methods and the rationale for the study design. The data collection procedures and implementation issues will then be described. Ethical issues and the strategies for data analysis will be discussed, and finally the results are presented and discussed.

8.1.1 Research design and methods

Mixed quantitative and qualitative research methods were adopted for the study. Participant observation of the care of the patients by the RRS team was the principal method for this element of the research. As Bowling (2002) and May (1993) argue, it is the best method for understanding the experience of people. In-depth interviews were also conducted with patients, relatives, the RRS team members and collaborative care professionals. During the participant observation and in-depth interviews, a field diary was kept by the researcher, rather than comprehensive tape recording and transcribing, mainly because of limited resources.

8.1.2 Procedure of data collection and implementation

Participant observation and in-depth interviews with patients, relatives, the RRS team and collaborative care professionals were carried out two or three times a week between April 2001 and April 2002. The monthly RRS meetings and annual team-building away day were attended. The main difficulties encountered with data collection for this study corresponded with those in the core study (see Chapter 9). A full account is given in Section 9.3.4.

8.1.3 Ethical issues and strategies for data analysis

The principal ethical consideration in this study was to maintain the confidentiality of the personal data. The names of the interviewees and of the people observed were not entered into the research database. The requirement of national data protection legislation and research conduct policies of the University of Sheffield were upheld, and due regard given to the legal and ethical requirements to maintain data safety and confidentiality. The study was approved by the Barnsley NHS Local Ethics Committees (Appendix 5).

The participant observations and in-depth interviews were used particularly to collect data about problems during setting up of the new RRS in the first year. The various sources were converted into text-based qualitative data and grouped by theme to enable quantitative analysis (Bowling, 2002).

8.2 Main results and discussion

During the participant observation and in-depth interviews, a field diary was kept by the researcher. The main contents of the field diary were:

- unexpected and unusual events during the care and in working with other team members and collaborative professionals,
- recurrent problems in the implementation of the service,
- unmet needs of service users and their relatives,

The following are examples of the field diary.

> 14 /June/2001
>
> A patient came with UTI (urinary tact infection), and chest infection to RRS. Dr. **** did not hesitate to give consent to cover medical treatment and agreed to put the patient in **** nursing home. The RRS team visited the patient regularly at the nursing home. Then, RRS team found that the patient had another problem, with cellullitis on his hand. The patient might need further medical assessment and antibiotic therapy. RRS team contacted the GP, who consented to cover the medical responsibility but said that the care-home was outside the GP's catchment. That is why he refused to visit the patient although he agreed to cover the medical care and to put the patient in the care-home. The GP has been already paid for covering medical responsibility because the patient was at the end of RRS care. Thus, RRS team had to

enlist another GP in the area to provide temporary medical cover for the responsibility.

30/Oct/2001

The team leader was concerned about the increasing referrals for free residential care for chronic or terminal ill patients, as from social services. A GP referred a patient with a chronic disease (Parkinson's disease) to RRS team yesterday. The team leader said that she found it very difficult to refuse a patient who was referred by a GP. Sue mentioned that the GP obviously could have referred the patient to Social Services or the GP's own beds, but the GP preferred to refer patients to the RRS.

Another concern of the team leader is that some patients are able to manage at home but they are likely to stay in a residential or nursing home; and some patients ask for continuing institutional care. Among the aims of the service, one is to prevent patients' long-term institutionalisation, but some were being encouraged to use residential care long-term. Additionally, some patients' relatives and their GPs request nursing-home care rather than domiciliary care, therefore the actual aims of service (to prevent long-term residential care) are being thwarted.

At the same time, some patients who are not mentally confused and are independent are complaining about their difficulties they experienced in the nursing home. Most nursing home or residential care-homes do not distinguish whether they care for mentally disabled older people or for physically disabled people. Some patients who were mentally very dependent, mentioned that it was a shock to be in such place where some people are wandering and shouting and some of them are very disabled.

4/Dec/2001

Problems with the use of equipment including urine bottles, commode chairs, and bed pans etc. on weekends were discussed. On weekends (Friday evening to Monday morning), the home-loan service is not available, therefore the RRS team has been struggling to borrow equipment. Some staff asked the team leaders to create a RRS store rather than borrowing from the district nurses' store at weekends. Some of the borrowed equipment, for example bed-pans and commodes, should not be returned by the RRS team but by the home-loan service, because the dirty equipment should be cleaned. There were also complaints from the home loan service, district nursing service and resource centre about the loss of equipment through RRS team loans.

RRS team mentioned that since a social worker started to work for RRS, referrals for social problems has increased. Referrals to social workers had been greatly delayed over Christmas and New Year's Day, so the patients with social problems were referred because a social worker [in the RRS team] is able to use a voucher for free social care-home beds, and the RRS is a 24 hours service.

The problem with communication is not only between care staff in different care services but also within the RRS. For instance, whenever a duty is changed, usually in the morning, all care staff who are on the duty attend the hand-over meeting, however, therapists and social workers still expected nurses or the other care staff to prepare formal paper work for referrals to physiotherapy, occupational therapy and social work within RRS. This was complained about by the RRS-team nurses.

22/01/02

Until recently, recording of the performance of RRS has been disorganised. For example, the order and contents of the recording were done differently by the RRS team members from week to week and some records of the patients staying at home were missing. In particular, the records of the patients who were not accepted were not properly completed. That is why they often did not know whether a patient had previously been refused even after a few days. The RRS Secretary had begun by binding records and arranging them by the order of the name and time.

A patient with Parkinson's disease has been referred to RRS by his GP. The patient has already received RRS twice. The last use of RRS was a few weeks ago. In fact, the patient did not have an acute medical problem but his mobility has deteriorated. The GP's referral to the RRS was refused, and the patient referred to the community social worker and community physiotherapy for respite care. The GP agreed with the decision of the RRS team. However the patient and the patient's family were annoyed with the RRS team and especially the GP. The informal carer said that the patient's condition had improved during the 4-day hospital stay. He could walk after discharge from the hospital. However, the patient's condition was the same before and after he received RRS. The patient was happy with the staff and his place in the resource centre during the RRS stay, but there was no medical treatment, which is why the patient's condition had not been improved. RRS said that the referral to hospital or community services cannot be decided by the RRS team but by his own GP. However, the patient and carer consistently asked the RRS team to refer the patient to hospital. Also, they complained about the occupational therapist in the RRS team who recommended getting the stand trolley. When he could walk, the patient was charged £100 for the trolley but he could not use it for a long time because he could not walk.

The prevalence of recorded problems

There were 203 separate diary entries, with an average length of a little less than 200 words. The data were entered into a field diary kept by the researcher during the periods of participant observation and in-depth interviews. The different problems reported in the diaries were coded iteratively, with problems identified late in the analysis being searched for in the entire set. The problems with frequencies of 5 or more are ranked in Table 8.2. The most common problems are discussed in the following section.

Table 8.2 Problems with the implementation of the RRS (Percentage of 'problems' data units)

Issues	n*	%
Eligibility of the patient to RRS care	44	21.8
Medical interventions	24	11.8
Staff management	22	10.9
Communication[1]	18	8.9
Patients' placement for care during RRS episode	15	7.4
Recording and management of patient documents by multidisciplinary team	14	6.9
Quality of care, or relationships with other care agencies	11	5.5
Medical cover by the patient's own GP	11	5.4
Inconsistent referrals / variable or non-availability of the care service / lack of publicity about RRS	10	4.9
Variable working load / insecure working environment for RRS team	8	4.0
Achieving consistency in referral decisions by the RRS team	7	3.5
Questions about financial responsibility between RRS and other Services	7	3.4
Characteristics and behaviour of RRS patients	7	3.4
Rapid response to the needs of patients and caregivers / discharge care	5	2.5
Total	203	100

Note: 1. Communication among RRS team members and between them and professionals in other care services; * The frequencies of the various difficulties or issues discussed in the first year.

Source: Field diary from participant observation of the care of the patients by the RRS team and in-depth interviews with patients, their relatives, the RRS team members and collaborative care professionals two or three a week between April 2001 and April 2002.

8.2.1 Characteristics of RRS client groups

By monitoring RRS patients for the first year, some differences with the clinically matched hospital patients were observed. Some RRS patients did not want to enter hospital and preferred to stay at home. For example, a patient was suffering a serious cellullitis on his legs and many symptoms of undiagnosed diabetes. The patient was ill enough to admit to hospital but refused to go. He said, 'I am 93 years old. I will die soon and there is no point in going to hospital. I don't want to leave home'. A team member mentioned that in the rural areas, many older people who used to work on farms were reluctant to go to hospital.

Patients who needed a simple medical intervention or observation but no further medical assessment or investigation were likely to be admitted to the RRS. Patients with a terminal illness might be a good example. Community palliative care in Barnsley has too little capacity for local needs, with the result that many patients with a terminal illness were referred to RRS despite the limited duration of its care. These patients and their relatives commonly expected the RRS team to provide support or care rather than a treatment or intervention that caused the patient pain or discomfort.

8.2.2 Eligibility of the patients

Different understandings of the eligibility criteria for the RRS were disputed throughout the year between the team and referrers. For instance, referrals increased through the year of patients: with unmet personal care needs, in association with the unavailability of formal or informal care, reduced mobility, frequent falls, chronic illnesses, a mental health problem (e.g. increased confusion) or alcoholism. Additionally, the eligibility of patients with a palliative care need led to persistent disagreements between the RRS team and referrers.

There were many referrals of patients who were too ill to be cared for by the RRS team, who needed medical interventions that the RRS team could not provide, were younger than 65 years, or who had problems such as constipation. These groups of patients used to be cared for by district nurses. In fact, some referrers attempted to use RRS as respite or emergency social care. As indirect evidence, the referral of these groups of patients noticeably increased every Friday evening and on bank holidays (including Christmas and New Year's Day). It is probably relevant that few social workers are on duty on weekends and bank holidays. A reason for the increase in the referrals for those patients is that it takes a long time for those patients to be assessed by a duty social worker, and the RRS responded quicker than other community services.

When the RRS team refused to admit these patients to the care scheme, sometimes arguments occurred between the care team and the referrer. Referrers were likely to believe that the patients had a medical problem, and the RRS team that they had a social problem. Most referred patients had chronic illnesses, which lead to the disagreement. There were also arguments about whether patients with the problems should or should not go to hospital – one aim of the RRS was to save hospital beds.

Some referrers believed that the RRS, an intermediate care scheme, should have different admission criteria from the acute hospital, to fill the gap between hospital care and community care.

The eligibility of RRS patients requiring palliative care was frequently discussed. Due to the shortage of community beds for terminally ill patients, and the variable arrangement of discharge care by the acute hospital staff, some patients requiring palliative care were discharged from Barnsley District General Hospital (BDGH) to their homes without appropriate support. Some were then referred by a district nurse or their GP to the RRS care scheme. However the RRS team believed that the care scheme is inappropriate for these patients, because it provides a maximum of seven days care at home and 14 days care in either a resource centre or in a care-home. It means that terminally ill patients that require palliative care must move to another place or services.

8.2.3 Medical interventions

Although the number of patients who needed medical interventions was small, continuing problems were experienced with inappropriate guidelines for their administration and with staff training. From July 2001, the RRS provided intravenous fluid, antibiotics and blood-transfusion therapies. However, it was unable to provide the interventions uninterruptedly, because the qualified staff resigned, and then there were delays with training replacement staff.

The RRS was managed by the Barnsley Community Health Care Trust (BCHCT) but aimed to provide care as would an acute hospital for some patients with acute illness. It had difficulty finding the resource for staff training in interventions such as intravenous fluid, antibiotics and blood transfusion therapies that had been provided in hospital. As new staff nurses joined from November 2001, the RRS team leaders were enthusiastic that all nurses should be trained to carry out the medical interventions, but there were delays of about 6 months until April 2002. The RRS tried to access the training package at BDGH but it was being revised, and they had to turn to the Northern General Hospital, Sheffield, and the District General Hospital in Doncaster. In the event, the RRS was unable to send staff on these training courses because of budget complications between the Trusts. Finally, the RRS was able to access a training resource at a hospital in Rotherham. While the RRS had difficulty providing staff training for some medical interventions, the referrals for them continued.

The RRS was not however able to accept the patients, so some referrers became confused about whether the RRS could provide the treatments.

Although the RRS is required to provide acute medical interventions, its working practices and environment are very different from those of an acute hospital. Some hospital procedures for some medical interventions were found inappropriate for the RRS. For example, in an acute hospital, the drugs for intravenous therapy are usually checked by two nurses, but on a RRS shift often only one nurse is on duty. Not surprisingly, the staff nurses were worried about possible accidents and the legal problems that might arise. The RRS has lacked adequate support in many comparable ways.

In spite of the lack of support, the RRS team has been enthusiastic to engage in staff training. Most of the RRS support workers (or care-assistants) used to work in the community and had little experience of acute hospital practice. They needed education about checking blood-sugar levels for diabetes, about vital signs and about record keeping. The RRS has provided training for support workers, and organised study days to teach them about the common illnesses of older people, such as heart disease, Parkinson's disease, and cerebrovascular disease. Most qualified nurses were untrained in male patients' urinary catheterisation or handling the syringe driver. When covering district nurses' night shifts, the referrals for the intervention were increased, but at those times the team had to transfer the patients to the BDGH Accident and Emergency unit. It is therefore planned that all qualified nurses will have training for these interventions.

8.2.4 Staff levels and deployment

Another frequent implementation issue related to RRS team management. The RRS has a small number of staff and provides a 24 hour service for a maximum of 13 patients at any time. When the RRS was established, it comprised one team leader (G grade nurse) and 4.5 full-time staff nurses (E grade), a physiotherapist and support workers. Subsequently, RRS recruited 2.5 full-time team leaders, 4.5 qualified nurses, a physiotherapist, an occupational therapist, a social worker and support workers (care-assistants). Therefore, when staff were sick, or on holiday or had resigned, the RRS struggled with staff allocation. The team leaders are responsible for assessing patients and the management of the team. Their pay is higher than other staff nurses, but they work less at night. When a staff nurse resigned and a new staff nurse was training and only worked in the daytime, a few nurses had to cover all the night shifts. On such occasions, or when one of nurses was on holiday or sick leave, it was very hard for the team leaders to allocate off-duty staff without causing complaints.

RRS team members visit patients independently and at different times according to the care plan. Although the RRS team tried to visit at times related to patients' needs, unexpected traffic delays, incorrect or incomplete addresses and other reasons for not reaching the patient, unexpectedly long previous visits and other factors frequently caused late arrivals. Consequently, different team members were sometimes visiting a patient at the same time, and sometimes a team member did not attend when they were needed. When several team members visit a patient at the same time in a nursing or residential care-home, the staff were not pleased. In summary, it was very difficult for the RRS team leader to monitor and allocate the staff's home visits according to both the care plans and the preferences of the patient.

RRS was a new and is still changing. RRS team members sometimes faced problems and strain because they did not know with sufficient precision their roles and responsibilities. As a result, there were conflicts between team members, including disagreements about the guidelines. Since the first year of the service, the guidelines have been revised with more detailed specifications of each team members' roles and responsibilities. As the RRS settled in, it met another big service change. The creation of the Primary Care Trusts (PCTs) increased the problems and concerns of the RRS team members. Many rumours about the future of the service increased their worries, in particular about job changes, salary scales, number of working hours and holiday entitlements.

8.2.5 Communication

The issue of communication among RRS team members and between them and other care professionals was frequently discussed. Since RRS was established, it has rapidly changed. RRS team members had throughout the problem of adjusting their work in the developing service. Whenever a big change was announced or heard about, the team members characteristically were only partially informed. Contradictory understandings and views often formed, which led to disagreement and stress.

Although the RRS was provided by a multidisciplinary team during the first months, the members to a large extent worked independently. In particular, during the first months, therapists and support workers were not very involved in team communication. As the team has grown, it was found that individual members knew little about the other members' roles and duties. The importance of working together and of more communication became very clear. In order to reduce the problems, the RRS team arranged monthly and daily meetings at which nurses, therapists and social workers shared information about the patients. The RRS team kept learning and developing from their own experience.

Other examples of poor communication between the RRS team and other care professionals were observed. Some patients who had been refused RRS care were repeatedly referred by another referrer from either the same or a different care service. For instance, a patient who had been referred by A&E was not accepted by the RRS team but subsequently referred by a social worker. Consequently, some patients circulated from service to service, partly as a result of poor communication between the care professionals in the different care services.

8.2.6 Operating the placement rules

The accepted patients were normally supported and cared for in the patients' own homes, at the primary care resource centres, or in a residential or nursing home. Issues around the patients' placements for the care have been then one of the perennial problems of the RRS. To provide care in a patient's own home has numerous advantages, such as helping the patients adjust to independent living, lower costs for the service through the greater involvement of informal caregivers and support workers rather than qualified staff, and avoiding care-home fees. Furthermore, when patients are discharged earlier than initially planned, actual savings are made, in contrast to the situation with allocations to care-homes because beds for RRS patients are pre-booked and paid.

To respond to the pressure to reduce expenditure on winter schemes, the RRS tried to provide care at care-homes for 2 to 3 days rather than the full 14 days, and from June 2001 to provide more care at patients' homes. Put simply, RRS planned to minimise the duration of care in care-homes and to provide the required care in patients' own homes. Financial pressure also influenced on overnight-sitter service. It was originally planned to provide overnight-sitter care for four nights, but from November it was reduced to a maximum of two nights. Then if the patient needed further night-sitter care, reassessment was recommended every second day.

A small number of RRS patients were likely to become permanent residents in a care-home. It is hard to judge whether the staff of the care-homes tempted RRS patients to become permanent residents, but the admission and the hospitality of the staff might have made it easier for the patients and their family to choose and accept permanent residence.

On the other hand, there were some patients who were severely disabled and had great difficulty in managing at home but did not want to go either to hospital or to a care-home. Unless the RRS provided 24-hour support, it was very difficult to care for the patient. For some, three visits a day were insufficient, and in rare cases the patient's informal carers complained about the RRS. The team members reported that it was very hard to care for such patients, and they were worried about their legal liability in the case of accidents.

Another difficulty in meeting the needs of some patients in their own homes is to fit in with their regular daily activities, such as the times at which they go to bed, have meals, or bathe. Moreover, some disabled patients who had not been out and had been isolated for a long period appeared anxious to have visitors, including care staff, especially in the evenings. One patient mentioned that a few years ago she had had a call from a teenage stranger, since when she refuses to open the door to anyone after 4 or 5 o'clock. Also, some patients were obviously anxious about the visits by multiple team members in a day. On the other hand, some sociable patients who were at home alone were pleased to receive visits by numerous RRS team members, but others had difficulties unlocking the door for the care team. In that case, the key for the door was hidden outside the house or held by a neighbour. This situation sometimes increased older patient's worries, and sometimes broke down because of miscommunication between the team members.

Some independent patients without a mental health problem complained about their placement in a care-home. Most nursing home or residential care-homes in Barnsley admit both physically and mentally unwell residents, so some mentally independent patients found themselves for the first time living alongside those with cognitive deficits. One said it was a shock to be in such place, where people were wandering and shouting and some had severe cognitive impairment.

As mentioned above, it is not easy for the RRS team to place patients and meet their preferences. It was particularly difficult to place patients in a care-home accessible to their GPs, especially when the patients' preferred area and the GP's catchment areas were different. For example, a patient's family wanted the RRS team to place the patient in a nursing home near to the family. This was done, but then the GP refused to provide medical cover because the home was outside the GP's catchment area. This resulted in the patient being transferred to A&E again, and then placed in another care-home inside the GP's catchment area. For such reasons, it was not at all easy for the RRS to arrange a placement that met the needs of patients, relatives and the GPs. Whenever the preferences were different and irreconcilable, there was a serous impact on the care of the patients. The staff have shown great dedication and tenacity in overcoming the problems but not every dilemma was solved.

8.2.7 Recording and management of patient documents

Analogous to the problems that the team haye had with communication, there have been persistent disagreements between management and staff on operational reporting and data. RRS first used the recording systems that were developed and used by the district nurse service. The separate records for nurses, therapists and social worker contained much duplication, while some useful information from the patients' assessment was omitted and some information was unnecessarily documented. As examples of the problems, initially records were not kept of essential information such as the contact telephone numbers of the patients and the residential or nursing home staff who were caring for RRS patients, and secondly the discharge plans. On the other hand, duplicate functional assessments were collected by nurses, therapists and social workers. The inherited record forms included unnecessary mandatory assessments about pressure sores.

There have also been instances of the inappropriate management of patients' records. Some patients' records went missing at the patients' home, and some papers were kept haphazardly. In particular, as mentioned earlier, inadequate records were kept of patients who were not accepted by the RRS. As a result, when the same patients were referred to RRS again, a few were accepted by another member of RRS team. On occasion, the patient's condition had changed, but some of these 'reversals' were inconsistent decisions by RRS team members.

With the growing size of the RRS team, the problems described above magnified. It was therefore decided in October 2001 to develop a dedicated RRS own patient record system and for it to be directly managed. The forms have since been modified several times. In the interim, different assessment and record forms were being used by the staff concurrently. It took many weeks to agree the style of the forms. Although the new system is simpler than the previous arrangements, it was not easy for the staff to get used to the changed forms. With great effort, the RRS team has successfully developed their own patients' records.

There were further changes when the RRS was merged with the Primary Care

Trust in April 2002, and the recommended single assessment system was implemented. The advantages of the new single information management system are that it will save professionals' and patients' time on assessment, and enable all care professionals to access information about patients. It was expected that the single assessment system would be established from May 2002. The RRS team had another difficult time getting used to new of information system. The management of patient records has also been greatly improved. Binding records and keeping papers in order by patients' names and month were well organised by the secretary of RRS from December 2001.

8.2.8 Quality of care, sharing responsibilities and relationships with other care agencies

Some patients stayed in private care-homes and their relatives sometimes complained about the shortage of staff, their incompetence, the inconvenient buildings, the poor environment, and maladministered interventions in the care-homes. Before a social worker joined the RRS team, the referrals of discharged RRS patients to the social services were difficult to process as well as subject to long waits. As mentioned before, while joint working with other care professionals in other agencies has many advantages, it was new to most of the staff involved. It takes time for care staff to get used to working in new ways. Both the RRS team and other agencies' staff settled into the new arrangements during the first year. As an example, the RRS extended its working contacts to voluntary organisations such as Age Concern Barnsley, which provides free or low cost-home care and advocacy support services. In January 2002, RRS invited Age Concern Barnsley to a presentation about their services. Since then, discharged RRS patients who were on a long queue for social services have been introduced to Age Concern services.

8.2.9 Medical cover by the patient's own GP

Many problems with securing medical assessments or interventions occurred. GPs were normally informed by the RRS team about the patient's medical states, care and discharge plans at discharge unless the patient's condition changed during the RRS care episode. A GP's medical assessment or decision for medical intervention was however required when the patient's condition deteriorated or another medical problem presented.

For diverse reasons, such as the lack of GP time for the extra RRS work, or the GP's low commitment to the service, there were many problems with medical assessments and interventions for the RRS patients. A few of the GPs who consented to provide medical cover were reluctant to visit patients when they needed medical assessments or treatments. Some sent their patients to BDGH in the middle of care episodes. In a few extreme cases, patients had to register temporarily with another GP. As another example, there was a RRS patient who was constipated. The patient was so unwell that the RRS team requested the GP to examine the patient (rather than administering an enema). The patient's own GP was however reluctant to visit the patient, and said that if the RRS team could not cope with the patient, she should go to hospital. The RRS team had to ask another GP to provide the medical care for the patient.

It would be precipitate to conclude from the cases above that the provision of medical cover by the patients' own GPs was unsuccessful. As long as the patients' medical conditions did not change, few difficulties and conflicts were observed. Although the incidence of the breakdown of medical cover by the patients' own GPs was low, when it did occur the impact on the patients and on everyone's confidence in the RRS was a matter of great concern and, of course, potentially very serious.

8.2.10 Inconsistent referrals, variable service availability and inadequate information

Inconsistent referral practice by care professionals and in different parts of the health district occurred throughout the year, and were most apparent during the early stages. For instance, patients from the western districts of Barnsley had been regularly referred by the GP in the early months since but from June 2001 were precipitately withdrawn. A team leader believed that the reason was a misunderstanding about the budget between the GP's practice and the RRS. The team leader visited the practice and explained the budget for RRS patients and the compensation arrangements for GPs' medical cover. Following the visit, GPs in the area reinstituted referrals to the RRS.

Inconsistent referrals by individual GPs were apparent and often discussed, and some GPs were clearly much more likely to refer their patients to RRS than others, while some never referred to the service. The very uneven referrals might have expressed either GP preferences or their lack of information about the RRS. The team made a great effort to reduce uneven GP referrals. They sent letters to all GPs in Barnsley about the criteria for RRS patients, and later about the achievements of the service. Team members also gave presentations about RRS to care professionals in the community.

Increased referrals by GPs and decreased referrals by hospital staff were observed from the middle of the first year. As is found in other care services, a strong seasonal pattern to the number of referrals was observed. Referrals steadily increased after RRS began in December 2000, but then decreased during the summer and increased again in the following winter. Another decrease occurred in the spring of 2002.

8.2.11 Variable working load, insecure working environment for RRS team

RRS provided cover for the district nursing services from midnight to 8 o'clock in the morning by a local agreement between the care agencies. The RRS night staff nurse worked on Ward 2 in the Mount Vernon Barnsley Community Hospital until there is a referral to the RRS or the district nursing service. The nurses who most often worked the night shift reported that the load was getting heavier, and that the district nurses were making increasing demands. Occasionally referrals for the RRS and for the district nursing service came together and were unmanageable by one staff nurse. Such unexpected demands on the night shift caused stress.

Another concern has been the insecure working environment for patient visits at night, especially where only one staff nurse was working. One RRS team member who was on night shift was verbally abused on a public road. The RRS team requested the co-ordinator to allow one staff nurse and one support worker to work together at night. The request was not accepted for budget reasons. To reduce the insecurity, the switchboard was asked to check the safety of the night staff. Additionally, the co-ordinator enabled the team to leave a patient referred at night by the hospital staff in A&E until the morning. If A&E was struggling with beds or staff, the RRS team deployed a support worker to support the RRS patient overnight.

8.2.12 Achieving consistency in decisions on referrals by the RRS team

Inconsistent referral decisions by the qualified nurses in the RRS were observed, especially during the early stages of the RRS. This was partly due to the poorly defined criteria for RRS patients, and partly to different interpretations. For instance, in the first few months, the staff nurses were more likely than other nurse categories to refuse referred patients. As another example, some patients who were younger than 65 years were correctly refused by staff nurses, but accepted by others with the aim of saving hospital beds. Similarly, some patients were refused by a RRS staff nurse because she thought that the patients were ineligible, but accepted by another staff nurse on the following shift.

The comparative influence on care placement of the RRS team and GPs became an issue. For instance, a GP referred a patient with Parkinson's disease but without an acute medical problem. A RRS team leader reported that it was very hard to refuse a patient who was ineligible but had been referred by a GP. As the performance data shows, referrals by GPs steadily increased over time, but referrals by hospital staff were stable. Hospital staff referrals had a higher non-acceptance rate than GP referrals. The differential acceptance rate is consistent with the hypothesis that GP's recommendations carry more weight than those made by other health professionals.

The problem of E-grade nurses making decisions on night referrals was an issue. During the day, the intermediate care co-ordinator and G-grade nurses (team leaders) are normally at work, but at night only one E-grade nurse is on duty. They have sometimes found it difficult to make the right decision, reflecting their relatively short experience of being in charge in emergency situations. For instance, the RRS team used to cover district nurses' night shifts. Then, referrals to the RRS by A&E and from district nursing staff were received simultaneously. The E-grade nurse in charge at night met the difficulty by making the decisions. To resolve the difficulty, the co-ordinator of RRS stipulated that RRS work has prior claim to covering district nurses' night work.

8.2.13 Unclear resources between RRS and other services

A lack of clarity about both payment arrangements and the availability of prosthetic and aids equipment between RRS and other services caused misunderstanding and inconvenience, especially with respect to medical interventions such as intravenous fluid or antibiotics therapy, ambulance services, blood transfusions, use of nebuliser, oxygen therapy, and urine or blood tests. This issue and the calls on their limited finances raised concerns among the managers of the primary care services. The patients who needed these interventions used to be cared for at the acute hospital. Primary Care have no funds with which to finance the interventions for RRS patients. In fact, the lack of clarity about which agency had the financial responsibility for the intervention was quickly clarified, but the consequences of the misunderstanding lasted a long while.

Conflicts in the provision of equipment or material supplies were sometimes observed between care-homes and the RRS. For instance, a patient who came to RRS with burns and who needed intensive wound care was placed in a care-home. The patient frequently needed a massive dressing change, and the staff in the care-home were not sure where the dressings would come from. Problems with the use of equipment such as urine bottles, commode chairs, and bed-pans have also been observed at weekends. The home loan service was not available, so the RRS team struggled to borrow from other services. Some staff in other services asked RRS team to create its own store rather than borrowing from the district nurses' store. In addition, complaints were made about the loss of equipment and difficulties with stocktaking by other services, such as the home loan service, district nursing service and the resource centres.

8.2.14 Rapid response to the needs of patients and caregivers and discharge care

RRS needs to assess the needs of not only older patients but also of informal caregivers, because they provide care for the RRS patients. In particular, the families of the patients having RRS care at their own home are significantly involved. As an example, some informal older caregivers who were fragile and neglected themselves caused concern. In that case, RRS should relieve the informal caregivers from caring through providing RRS care for the patients in a care-home or resource centre. As another example, some patients had been inappropriately cared for by their relatives. In such cases, the RRS team had to provide education in care to the informal caregivers. Overall, the needs of the patients' families generated substantial work for the RRS.

Another difference from acute hospital care is that the RRS has to consider how well a patient manages independently at home. The different approach or 'ethos' may be because the RRS is provided by multidisciplinary staff. As evidence in support of the hypothesis, the needs of older patients for community health and social care are more quickly responded to by RRS than by the community health or social care services. For a simple example, the queue for the aid and adaptation service is long, therefore patients must wait for the service for several months, but RRS patients access these services within a few weeks because their needs are strongly advocated by the team's physiotherapist and occupational therapist.

On the other hand, the RRS sometimes encounters a professional dilemma, as when they discharge patients who are not well enough, simply because of the rules about the maximum duration of their care. Some patients who need continuing care are transferred to Mount Vernon, the social services or BDGH. Being transferred may cause stress or confusion to the patient and their family. If the patient is transferred to the social services, the patients come under their means-tested 'services for payment' regime. This requirement angered some patients and their families. Another difficulty was that the patients who still needed physiotherapy should be referred to the community physiotherapists. The RRS team found however that the availability of some community care services, notably physiotherapy, was variable by the district.

8.3. Summary and conclusions

Recent National Health Service policy developments have featured a rising interest in innovative services for chronically sick and dependent older people. During the last three years, there has been especial attention to the nationwide introduction of 'intermediate care' services. Although the new way of joint working brings many advantages to the patients, there have been both teething and recurrent problems in their implementation, partly because the care professionals had never previously worked in this way and were unfamiliar with its requirements.

The interpretation of 'eligibility' to the Barnsley RRS scheme was disputed throughout the year between the team members and the referrers. Many referrals of patients with a social problem were caused by the unavailability of formal or informal care, reduced mobility, chronic illness (without an acute medical problem), or a mental health problem. Some referred patients were too ill to be cared for by the RRS team, while some referrers attempted to use RRS as respite care. Referrals for such patients increased noticeably on Friday evenings and bank holidays. Other frequently discussed issues were inconsistently provided medical interventions, the problems of staff management and delayed staff training (due to the lack of resources). There was widespread and persistent misunderstanding about the eligibility criteria among referrers. While a small number of staff provided a 24 hour service, the difficulties with maintaining the planned capacity, especially when staff were sick, on holiday or had resigned were also persistently discussed, as was securing the staff's safety in the different working settings. Unfamiliarity with working close together among the RRS team members, and between the RRS team and other collaborative care professionals, raised problems of communication during the early months. Besides, there were many other recurring problems with the patients' placements for care during the RRS episodes, with the recording and management of patient documents by a multidisciplinary team, with medical cover by the patient's own GPs and with inconsistent referrals.

Many services similar to the Barnsley RRS have been established throughout the country, although the nature and extent of service provision, including the integrated care pathway, criteria for eligible clients, the boundaries of the multidisciplinary teamwork, and the speed of development of the services have varied greatly. Nonetheless, efforts to share experience so as to avoid mistakes were scarcely observed during the implementation of the RRS, even between nearby services in the region.

Chapter 9

The outcomes of the RRS intervention for patients: a quasi-experimental comparison between RRS and matched hospital patients

Various kinds of hospital avoidance schemes have been established throughout the UK. The assumption is that they can make a real difference to the ability of older people to maintain their independence, remain living in a community setting for longer and, some see as the driving policy imperative, save hospital acute beds. There is however scarce evidence to support the assumption. This local evaluation study therefore aims to develop the evidence by (a) examining whether the users were appropriately selected patients and those at high risk of a hospital admission, and (b) comparing the hospital avoidance scheme (RRS) patients with acute hospital patients that were matched by the service user criteria of the hospital avoidance scheme (RRS). A secondary aim was to collect information that will inform the national appraisal of intermediate care schemes.

This chapter begins by restating the primary research questions. Methodological issues will then be discussed and the study design outlined. The main topics to be examined are the duration of the care episodes, the physical and emotional functioning and satisfaction levels of the service users at discharge, and the status of both RRS patients and hospital patients 90 days after the service episode. The strategies for the data analysis are outlined, the results presented and the findings discussed.

Research questions

A. Service outcomes

a) Were there differences between hospital avoidance scheme patients and the hospital patients in: (a) the duration of care episodes, and (b) their physical and emotional functioning at discharge?

b) Were there differences between the RRS patients and the hospital patients in discharge destination (or place of residence), readmissions, falls and mortality at 90 days after the care episode?

c) Were there differences between the RRS patients and the hospital patients in health and social service use 90 days after discharge?

d) What is the best predictor of the duration of a care episode?

e) What is the best predictor of the patient being admitted to a care home as a permanent resident within 90 days of the care episode?

f) What is the best predictor of the patient being readmitted to an acute hospital within 90 days of the care episode?

g) What is the best predictor of a patient's death within 90 days of a care episode?

B. The patients' satisfaction with the RRS service

a) Did the RRS patients and hospital patients have significantly different levels of satisfaction with the service that they received?

9.1 Study design

This section will first describe the selection of the subjects. The study design and data collection methods will then be discussed with reference to the strengths and weaknesses of alternative designs and methods.

9.1.1 Participants and final sample size

Participants

This evaluation focused on 150 older people who received the RRS. The sample size of 150 gave the minimum acceptable power for the study (as described below). Older people who were admitted to the RRS and gave consent to participate during April 2001 to May 2002 were recruited to the study. The same number of patients who were admitted to hospital and gave consent to participate during the same time, matched with the RRS patients, were then recruited to construct a hospital-based care comparison sample.

A leaflet for care professionals and service users that was published by Barnsley Community and Priority Services NHS Trust and Barnsley Metropolitan Borough Social Services (2001) indicated that the eligiblity conditions for the RRS scheme were: exacerbation of chronic conditions (*e.g.* chronic obstructive pulmonary disease (COPD) and asthma), acute care (*e.g.* cellulitis, deep-vein thrombosis and chest infection), reinsertion of a percutaneous endoscopic gastrostomy (in emergency only), terminal care, mild cerebrovascular accident or transient ischaemia, and dehydration. Another paper, 'Rapid Response Service: Interim Evaluation' pointed out that intravenous therapies would be provided by the RRS to administer medication, rehydration fluids, blood transfusions, subcutaneous infusions, low molecular heparin, nebulisation, oxygen therapy, phlebotomy and to obtain specimens (Barnsley Rapid Response Service, March 2001). In the same paper, the criteria for referral were stipulated as:

- the patient would otherwise be admitted to hospital
- the patient's GP is willing to accept medical responsibility
- the patient is aged 60 or more years
- the patient agrees to the care plan
- the patient has the potential to remain in the community after discharge from the scheme, and
- the patient is resident in the Borough of Barnsley.

One of the criteria, 'the patient would otherwise be admitted to hospital', was likely to be interpreted variously. In the event, the promised interventions (or care) were inconsistently provided as a result of the implementation difficulties faced by the staff and management in the first year. As a result, most referrals to the RRS did not meet the criteria and there was a difference between the actual characteristics of the service recipients and the operational criteria (as found in the monitoring study: see Chapters 7 and 8).

Consequently, it was not possible to match the control group patients by the main clinical problem of each participant from the RRS care scheme. Hence, the inclusion and exclusion criteria for subjects in this study were refined as in Table 9.1. The same number of patients, were matched by the following criteria and then selected from those admitted to geriatric wards at the Barnsley District General Hospital to construct a hospital-based care sample to compare with patients who received RRS. Mentally disabled patients and those with significant cognitive deficits older people were excluded by reviewing the routine clinical assessment in the patients' record.

Planned sample size

A previous study that evaluated the effectiveness of intermediate care in a nurse-led in-patient unit (Griffiths *et al.*, 2000) provided guidance on the required sample size. The study described here aimed to recruit 300 patients (150 from both the RRS and hospital). 80 per group would be powerful enough to detect a difference of 1.2 to 1.5 points on the Barthel index (a patient outcome measure) (α=0.05, power=0.8) according to the tables provided by Machin *et al.* (1997).

Table 9.1 Sampling inclusion and exclusion criteria

RRS patients	Hospital patients
Inclusion criteria	
➢ The patient should be aged 65 or more years and with acute illness.	➢ Patients with conditions that meet the criteria of the RRS.
➢ Patients should give informed consent	➢ Patients admitted for the interventions that were planned to be available through the RRS, regardless of whether their availability had been consistent or they had never provided.
	➢ Age matched
	➢ Sex matched
	➢ Patients should give informed consent
Exclusion criteria	
➢ Cognitively impaired people were excluded by reviewing the routine clinical assessment in the patient's record.	➢ Mentally disabled older people were excluded by reviewing the routine clinical assessment in the patient's record.
➢ Patients transferred to an acute hospital in the middle of the RRT care scheme would be excluded.	➢ Patients who needed medical treatment or interventions not available through the RRS, such as orthopedic treatment after a fall, diagnosis or treatment of acute heart disease, or acute cardiac ischemic disease.

9.1.2 Research design and methods

Research design

It was decided to use both quantitative and qualitative methods for this study. Close attention was given to what variables to examine, how these could be operationalised, what type(s) of data to collect, at what time points to collect the data, and the methods employed for data collection (Sim and Wright, 2000). Quantitative designs provide answers to 'what' type questions being based on a large number of respondents or cases. Qualitative approaches are useful in exploring 'why' type questions and facilitate the understanding of the beliefs and attitudes of individuals in a way that may be not possible with quantitative approaches (Peat *et al.*, 2002; Sim and Wright, 2000).

For this study, a quantitative approach had many advantages. It would enable tests of hypotheses, such as that the RRS can be an alternative to hospital care for older people with acute illness. Nonetheless, the quantitative approach also had limitations, especially if confined to the analysis of operational data, for this provided no information from the patient's perspective, especially in terms of their satisfaction with the care received. Thus, a mixed design of quantitative and qualitative methods was essential for this study. The main part of the questionnaire comprised closed or pre-coded questions. Semi-structured and open-ended questions were added to elicit qualitative responses on the patient's satisfaction.

A longitudinal design that collects data at more than one point in time is demanding of the researcher's time and requires additional resources. It has, however, substantial advantages. It establishes time relationships between variables, that is, which variable precede and predicts which other variable (Grady and Wallston, 1988; Sim and Wright, 2000). A prospective longitudinal study was necessary for this study, to identify the outcomes for the patients at discharge and three months later.

A randomised controlled trial (RCT) in which all participants have the same chance of being assigned to differentiated experimental and control study groups is the most powerful way of demonstrating the causal effect of an intervention (Jadad, 1998). But an RCT needs require all other variables (or influences) to be identical for the compared groups, and requires a single defined intervention and homogeneity in the patients. These conditions were not met by the Rapid Response Service. A more feasible option was a quasi-experimental design because although the researcher had no control over who received the service, it was still possible to replicate an experimental design by controlling for many extraneous variables through matching (Grady and Wallston, 1988; Sim and Wright, 2000).

Research methods

A self-completion questionnaire (SCQ) with pre-coded and open-ended questions was designed to collect information about the patients' characteristics, their physical and emotional functioning, and their satisfaction with the service. The large sample was enabled by the agreement of the RRS and hospital staff to distribute the questionnaires, but this did cause difficulties. Unfortunately the task was frequently sidelined by some members of the staff. To minimise the bias and maximise the accuracy of the responses, an interviewer-administered questionnaire (IAQ) was used for data collection (at discharge), and a self-completion questionnaire was used for data collection 90 days after discharge to reduce time and cost. (The phases of data collection were described in Section 9.3.1).

9.2 The selection and design of the instruments

For the data collection at discharge and at 90 days following discharge, two questionnaires were designed. Questionnaire 1 covered the patient's characteristics, assessed their physical and psychological functions, and collected data on the patient's satisfaction with the service. Questionnaire 2 included questions on health and social services use, readmission to hospital, admission to care home, and falls within 90 days following discharge.

Questionnaire 1

Several validated and well established instruments are available to measure the outcomes of hospital and community health services use, especially about physical and emotional well-being and satisfaction with the service. The *Barthel Index* (Mahoney and Barthel 1965) and the *Instrumental Activities of Daily Living* (IADL) assessment scale (Lawton and Brody 1969) are used to assess physical function. The *Philadelphia Geriatric Centre Morale scale* is used to assess psychological function (Lawton, 1975). These three are often used to assess well-being and function both in the hospital and community.

Although several scales and instruments to measure satisfaction with care have been developed and tested, few are relevant to care services for older people provided in the community. The selection was not therefore straightforward. It was decided that a new instrument, adapted to the particularities of the RRS, had to be designed. The two substantial procedures to construct a questionnaire were undertaken. First, the patient satisfaction concept and established instruments were reviewed and a new instrument for this study was then designed. Second, the new questionnaire was tested on colleagues and piloted through a small number of interviews with the population of interest. The two procedures and the final questionnaire are described below.

Questionnaire 2

Questionnaire 2 was designed for self-completion. In the pilot study, it was found that the majority of patients had either (or both) visual and handwriting problem(s). It was therefore decided to design as simple an instrument as possible. Questionnaire 2 is presented in Appendix 3.

Participant information sheet and consent form

A participant information sheet was attached to the front of the questionnaire (see Appendix 4). This explained the purpose of the study and what would be involved if the individual decided to participate. The confidential nature of the questionnaire was stressed, as was the fact that the participant could withdraw from the study at any time without affecting the quality of the care they received.

9.2.1 Reviews of the patient satisfaction concept and instruments

The patient satisfaction concept

In designing a patient satisfaction questionnaire, it is necessary take into account what constitutes patient's satisfaction and what factors can affect the level of satisfaction. According to Pascoe (1983), patient satisfaction is a health care recipient's reaction to salient aspects of his or her service experience. Satisfaction is both a cognitive evaluation and an emotional response to the structure, process and outcomes of the service. In this conception, the most important variable is missing, the patient's care needs, which greatly affects the level of patient satisfaction. For example, although a service may be running well, if it does not meet the needs of the individual patient, the level of satisfaction would be low. In this study which aimed to evaluate the rapid response service, the level of the service user's satisfaction would be an important indicator of both the quality and appropriateness of the service.

To measure satisfaction it is also necessary to identify the care needs of older people with conditions that span the chronic and acute categories. These conditions often complicate the need and best provider, as between community health, social and hospital care. Very few studies have examined the satisfaction of older people with community health services. It was therefore necessary to identify the principal dimensions of older people's satisfaction in a preliminary 'scoping' study. As mentioned earlier, patient satisfaction is mainly determined by six dimensions: medical care and information, food and physical facilities, non-tangible environment, quantity of food, nursing care, and visiting arrangements (HPAU, 1989).

The studies by Cleary and McNeil (1988) and Lochman (1983) had however emphasised that the amount of personal care received is related to the level of patient satisfaction, and that more personal care will lead to better communication and greater patient involvement. Unlike the studies mentioned above, Pascoe (1983) found that patient satisfaction is positively associated with the accessibility, availability and convenience of care. Gray (1980) also found that access to the service is a significant factor for patient satisfaction. In addition, Pascoe (1983) found that the quality of medical care is decided chiefly by the technical competence of the care provider, and that perceived competence is positively associated with the patient's satisfaction. As a factor related to the care provider, several studies have found that the patient's satisfaction is strongly influenced by the care provider's behaviour (Lochman, 1983, Like and Zyzanski, 1987). A study by Wilde, Larsson, Larsson and Starrin (1994) focussed on the quality of care from the elderly person's perspective found notable differences as between four types of care environment: geriatric departments, home nursing care, nursing homes, and service homes. Overall, however, it was found that the highest personal satisfaction with care scores were associated with successful medical care, care room characteristics and good personal attention.

Instruments of satisfaction with care

Patients' satisfaction with their medical care has long been associated with various positive health care outcomes (Hall and Dornan, 1988). Given its importance, various instruments to measure patient satisfaction have been developed for use in health services research. Four instruments appropriate for this study were found. One was a questionnaire to measure satisfaction with breast screening, the *Patient Satisfaction Questionnaire* (PSQ) (Ware *et al.*, 1976); the second a scale for the measurement of *Satisfaction with Medical Care*; the third the dimensions of the *Evaluation Ranking Scale* (ERS) (Pascoe and Attkisson, 1983); and the fourth the *Client Satisfaction Questionnaire* (CSQ) (Nguyen *et al.*, 1983).

The *Patient Satisfaction Questionnaire* (PSQ) is a self-administered measure of patient satisfaction and was designed for any adult population. It was developed using well-established theory, and great effort was taken to establish its reliability and validity. Although patient satisfaction is determined by not only medical care but also by factors such as information given, food, physical facilities, environment, nursing care and visiting arrangements (HPAU, 1989), the PSQ focused on the practice of one health professional: the doctor. Therefore, the PSQ was not suitable for this study, in which the subjects are community-based RRS patients. In addition, the PSQ was developed in the United States where health care is paid for by the patient. Therefore, the cost of the care can be a significant factor which determine the patient's satisfaction, but this is not an important factor for NHS patients in the UK.

The *Evaluation Ranking Scale* (ERS) was designed by the *American Academy of Family Physicians* and a team at the University of North Carolina for a study of the organization, utilization and assessment of primary medical care (Hulka and Cassel, 1973; Pascoe and Attkisson, 1983). Unlike most existing measures of satisfaction, the ERS concentrated on a rating procedure to differentiate patient response. It was developed for use with general populations in a primary health care setting. The content of the questionnaire therefore related to the needs of the generality of patients, not specifically older people with acute illness. For example, items relating to obtaining an appointment and waiting time are more important factors of care in primary care but irrelevant to the RRS (Wilkin *et al.*, 1992).

The *Client Satisfaction Questionnaire* (CSQ) (Nguyen *et al.*, 1983) was designed as a simple measure of satisfaction for a series of patient satisfaction studies at the University of California. The research aimed to construct and assess a simple client satisfaction scale for use in community mental health care settings, but the shorter refined version can be administered in other care settings. The CSQ was designed to be self-administered in 3 to 8 minutes (Nguyen *et al.*, 1983). The authors of the CSQ have performed extensive tests of reliability and validity. The two 18-item versions were produced to test split-half reliability, one measure of internal reliability that examines slightly different forms of questionnaire. Similar mean scores and a high correlation between the scores were found in a study of clients of a community mental health day-treatment programme (Levois *et al.*, 1981). In addition, a high internal consistency of the CSQ-8 has been found (Larsen *et al.*, 1979). Although the authors of the instrument had ensured its validity and reliability, the conceptual basis of the CSQ is not entirely clear.

The *Medical Interview Satisfaction Scale* (MISS) (Wolf *et al.*, 1978) was designed to measure satisfaction with the doctor contact than more generally with care. MISS is appropriate to use for adults in primary care or outpatient care. Similar to MISS, the *Patient Satisfaction Scale* (PSS), designed by Dimatteo and Hays (1980), focusses on measuring four categories of satisfaction: the communication, manner, competence and overall treatment of the doctor. This scale was therefore not applicable for this study in which the subjects are older people with different care needs and limited physical functions and given that the RRS is mainly provided by nurses.

Overall, therefore, the established questionnaires that measure patient's satisfaction were not applicable for this study. Nonetheless, the 8-CSQ was found to be broadly suitable although required adaptations (Larsen *et al.*, 1979). It could be used in the wide variety of settings used by the RRS. The refinements for this study included changing the words 'service', 'program' and 'help' to 'treatment' and 'care'. For the responses, the four-point Likert scale was not changed, but on the advice of health care professionals in Barnsley the response terms were refined from colloquial American to English usage. For example, 'no, definitely not' was changed to 'not at all'; 'no, not really' to 'mostly not'; 'yes, generally' to 'yes, mostly'; 'yes, definitely' to 'yes, entirely' and 'quite dissatisfied' to 'dissatisfied' (Appendix 1).

9.2.2 Pilot work

Tests of the refined 8-*Client Satisfaction Questionnaire* (CSQ) found that the internal consistency reliability of the responses was unacceptable (Table 9.2), and that uniformly high satisfaction scores were reported by the both hospital and RRS patient groups. This limitation has been noted in previous studies (Locker and Dunt, 1978; Zastowny *et al.*, 1983; Cleary and McNeil, 1988; Carr-Hill, 1992), in which older patients are likely to report higher levels of satisfaction than do younger patients. Bowling (2002: 482) stated that:

> People aged 65 and over express higher levels of satisfaction with health services than younger adults ... Such findings are consistent across different types of health systems, and regardless of whether surveys are sponsored by individual governments, private companies or independent research bodies.

Table 9.2 Internal consistency reliability of 8-CSQ with test samples

Patient group	Number of cases	**Alpha**[1]
RRS	10	0.5
Hospital	9	0.2
Total	19	0.4

Note: 1. Cronbach's alpha coefficient.

It was clear that a different questionnaire was necessary to differentiate the satisfaction level of the hospital and RRS patients. This was designed and trialled with pilot samples of the populations served by the RRS. When asked about their satisfaction with the service, majorities of those cared for in the hospital, the resource centre (designated for RRS), and the nursing home (designated for RRS) tended to talk about the quality of food and the kindness of the care staff. Many also mentioned uncomfortable beds and poor cleanliness. Some respondents regarded ease access to the service as a factor determining satisfaction with care. For example, one patient said that, "The care that I received is very good, but if I need to go into a hospital again, I would not like to come back here because it is too far for my family to visit me. In the hospital near my home, there wasn't a vacant bed. That is why I had to come here". Additionally, many older patients, particularly those with both health and social problems and who lived alone, expressed anxieties about managing by themselves after discharge. Referral for follow-on health or social services support and care, such as district nursing care, community physiotherapy, home care and home help, was therefore a strong influence on the patient's satisfaction.

9.2.3 The final questionnaire

The design and contents of the final questionnaire were informed by the review of previous studies and the lessons learnt during the pilot study. Nine dimensions or components of the patient's satisfaction with the RRS were identified, as follows:

- Good medical treatment or care for illness
- Staff attitudes and sensitivity to patients
- Quality of the care environment for recovery
- Quality of food
- Accessibility of the location for visitors
- Convenient and comfortable facilities (*e.g.* telephone use, bath, toilet etc)
- Respecting privacy
- Information about or referral for follow-on care after discharge
- Communication of information about the patient's condition and the reasons for treatment

Not all of these features were equally important for the RRS and hospital patients. For example, communication between the staff was more often problematic in the RRS (provided by only one or two nurses on each shift). The quality of the food was obviously more of an issue with hospital care than for home-based RRS care. Indeed, some home-based RRS patients cook for themselves, so food would not influence the patient's satisfaction with care. Nonetheless, the same questions were used for both groups to identify variations in the factors of satisfaction with care.

To discriminate among the uniformly high satisfaction scores by both hospital and RRS patients, the respondents were asked to choose the two or three factors with which they were most satisfied *and* least satisfied from the nine factors. Moreover, open-ended questions relating to about which they felt satisfied or dissatisfied, which were not on the list, and additional comments about the treatment and care, were included in the questionnaire (Appendix 2). Although the inter-rater reliability of open-ended questions is likely to be poorer than that of closed questions and also more time consuming for the researcher to analyse and for participants to complete (Sim and Wright, 2000), this qualitative approach was employed to increase the breadth and depth of the information.

9.3 Procedure of data collection and implementation

This section first describes the procedure of data collection. The response rates and pertinent ethical issues for this study are then presented, and it concludes with a discussion about the issues and problems which were encountered whilst the research was in progress and how these were overcome.

9.3.1 Data collection procedures

There were three phases of data collection: from the routine operational records, of patient outcomes and satisfaction *on discharge*, and of service outcomes *90 days after discharge.*

Phase 1: Collection of data from routine operational records

RRS patient admissions were recorded by the operational admission registration documents and each patient's medical records included a routine clinical assessment. These were reviewed to exclude the cognitively impaired. Similarly, the hospital patient admission records from the geriatric wards at BDGH and to exclude the cognitively impaired.

Phase 2: Collection of patient outcomes and satisfaction on discharge

Patients were contacted and interviewed for the second phase of data collection two or three days before discharge from the RRS or hospital.

Phase 3: Collection of service outcomes 90 days after discharge

All hospital and RRS participants who provided information at the second phase of data collection were sent the third-phase questionnaires approximately 90 days after discharge. For those who did not reply or provide information, the hospital operational data were searched to see if the patient had been admitted to BDGH or a nursing home or had died. The latter events are reported to the hospitals, often by GPs.

9.3.2 Response rates

In order to secure 150 RRS and 150 hospital patients who had consented to participate in the study, it was necessary to approach a larger number (Table 9.3). The required 300 patients were recruited during April 2001 to May 2002; and 184 RRS service users who met the inclusion criteria of the study were invited to participate. Of these, 150 (81.5 %) completed an interviewer administered Phase 2 (at discharge) questionnaire. At the same time, 196 hospital patients, who met the inclusion criteria were invited to participate, and 150 (76.5%) completed the interviewer-administered Phase 2 questionnaire. Compared to the response rate of RRS patients (81.5%), the hospital patients' rate (76.5%) was lower.

The main reasons for the different response rates is likely to have been the closer contacts that the interviewer had with the RRS team than with the hospital staff. Emotional stress with the admission to hospital may have also affected the consent rate of the hospital patients. The relatively supportive environment of people's own home (or even care homes) may also have promoted the higher response rate of the RRS patients.

At Phase 3 (90 days after discharge), among the 150 participants from the RRS, 91 (60.7%) had completed and returned the postal questionnaire while 25 (16.7%) had died. Therefore the true response rate was 72.8%. Among the 150 participants from the hospital, 101 (67.3%) completed and returned the questionnaire while 22 (14.7%) had died, so that actual response rate was 78.9 %. This rate was higher than those achieved by a cross-sectional postal survey about the aspects of primary care quality (Campbell *et al.*, 2001) and by a population-based postal survey about use and expenditure on complementary medicine (71 and 60% respectively) (Thomas *et al.*, 2001). It should be remembered that in general older people are more likely than younger adults to respond to surveys (Thomas *et al.*, 2001), but it was probably helpful that all participants were contacted by the interviewer and invited to respond to the two questionnaires at Phase 1. The second self-administered questionnaire comprised relatively simple questions, which may also have assisted the high response rate.

For a few participants who died after inclusion in the study, their relatives completed and returned the questionnaire, but others notified the death without completing the questionnaire. Some missing data pertaining to the responders and non-responders (as about readmissions to hospital, admissions to care home, and death after 90 days following discharge) were available in and collected from the hospital operational database.

Table 9.3 Response rates of the two samples

Time points of data collection	RRS		Hospital	
	Contacted n	Responded n (%)	Contacted N	Responded n (%)
Phase 2: face-to-face interview on discharge	184	150 (81.5%)	196	150 (76.5%)
Phase 3: postal survey 90 days after discharge	150	91 (60.7%)	150	101 (67.3%)

Note: Among the 150 RRS and 150 hospital participants, 25 (16.7%) RRS patients and 22 (14.7%) hospital patients died before 90 days after discharge.

9.3.3 Ethical issues

The principal ethical consideration in this study was to maintain the confidentiality of the patient information. An anonymous identity number was allocated to each subject and their personal name was not entered in the research database. The requirements of the national data protection legislation and the research governance policies of the University of Sheffield were upheld. Another important issue was 'informed consent'. The information sheet and consent form were explained and distributed to the patients by the interviewer. The information sheet included the background and purpose of the study, the reason why the patient had been chosen, participation and confidentiality policies and undertakings, contact names and telephone numbers, the invitation to participate and a statement of the unconstrained freedom to withdraw. The study was approved by the Barnsley NHS Local Ethics Committee (Appendix 5).

9.3.4 Implementation issues

This section will describe the phases of implementation concerned with interviewing, collecting hospital operational data, and survey of the patients' satisfaction with care.

Problems of interviewing and collecting information

One of the main difficulties with collecting information for this study was access to patients. The researcher planned to visit RRS patients placed in their own homes, the resource centres or nursing or residential care homes (NRCH). However, it was not always easy to visit the selected patients with the RRS team members. One was unreceptive and did not understand the value of the research evaluation, and believed that the evaluation study hindered the operation of the service. She was also distrustful and believed that the study was emphasising negative points. The team leader sometimes dissauded other team members visiting patients with the researcher, arguing that they were too busy. The level of non-cooperation at one point caused concern about the feasibility of the study.

The turnover of staff impinged on the operation of the RRS service than other NHS services because it was a small team. In fact, new staff members required training which was an additional load on existing staff members and further reduced the time available to help the researcher interview patients. Some patients were also upset when visited by several people at the same time (as when a trainee and the researcher appeared).

To overcome these difficulties, the supervisor of this study met the manager of the service, explained the significance of the evaluation study, and requested her to encourage the RRS team members' assistance. The researcher also tried to visit patients with the staff at more convenient times, as during the evenings and at weekends, and avoiding Monday mornings and Friday evenings when referrals were most frequent. Over time, and by attending regular staff meetings and a team-building day and becoming well known by the staff positive collaboration became the norm.

Such difficulties are more likely with an *independent* evaluation study in a professional setting, and may be generally avoided in evaluations sponsored by the providing agency or a statutory body. They have been reported as further evidence of the manifold uncertainties and anxieties that face front-line health care professionals who are given the responsibility to implement a service innovation without a clear practice specification.

Problems of surveying the satisfaction with care

Although the nature and confidentiality of the study were explained to all study participants, both the RRS and the hospital patients were reluctant to talk about their satisfaction with the care they received. Some participants even became anxious when asked about their care. According to McGarry and Arthur (2001), older care recipients may believe that an interviewer adversely influences existing and essential service provision. This study confirmed that some older people find it difficult to differentiate between the researcher and the service providers.

9.4 Strategies for data analysis

This section evaluates the appropriateness of the selected samples, the aims of the analysis, and the rationale for using particular statistical tests. The quantitative analyses will be described first, and then the analysis of the qualitative data from the open-ended questions will be addressed in Section 9.7.

9.4.1 Statistical analyses

Data were entered into the Statistical Package for the Social Sciences (SPSS) (Windows version 10.0) and checked for accuracy. Individual variables were initially explored by careful inspection of the frequency distributions before progressing to bivariate and then multivariate analyses. As most variables of interest were categorical, the bivariate relationships between variables were examined using chi-squared tests. According to the number of categories and the frequencies in each category, a continuity-correction chi-squared statistic, or Fisher's exact test were also used. Independent-samples *t*-tests were additionally used to find relationships between one categorical variable and one continuous outcome variable.

Multivariate statistical modelling and specifically analysis of variance (ANOVA), were then used to identify more complex relationships among the variables. This type of analysis produces a regression model in which the dependent variable is expressed as function of a combination of the independent variables (sometimes called predictor variables or covariates) (Altman, 1991; Bland, 2000). Logistic regression analysis was used to identify the multivariate factors that were associated with binary categorical variables. Regarding the selection of predictor variables from a large set, there is no 'right approach' or 'best model'. The two main approaches to logistic regression are step-up (or forward inclusion) and step-down (or backward exclusion) selection, both of which are satisfactory and have their advocates.

In forward selection, at each successive step the single variable which has the strongest association remaining unexplained variance of the dependent variable is entered into the model so long as the association is statistically significant. This step is iterated until the addition of an extra variable is not statistically significant at some chosen level (usually five per cent). The alternative, backward selection, procedure begins with a ' model' that includes all the independent variables, and removes insignificant variables one at a time until all those remaining in the model contribute significant explanation (Altman, 1991; Bland, 2000). In this study, backward selection method was used and variables with associations having a p value > 0.25 were removed from the model. The independent variables[1] were screened by establishing bivariate

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[1] Independent variables added to each model included: reasons for admission, 10 year age groups, living arrangement, referral agency or professional, informal caregivers, marital status, Barthel index scores, Instrumental Activities of Daily Living (IADL) scale scores, Philadelphia Geriatric Centre Morale scale score, duration of care episode, dissatisfied features of care,

associations for backwards stepwise variable selection, although the strategy saves nothing with forward stepwise regression. As Altman (1991, p.349) stated: 'selection should be based on a lax criterion, say p<0.2 or even higher, because variables may contribute to a multiple regression model in unforeseen ways due to complex interrelationships among the variables'. Therefore, the selection of independent variables was based on p<0.25 by establishing bivariate associations with the dependent variables using chi-squared tests, and a backward selection procedure was selected for choosing the best independent variables from a large the available set.

The models developed (or regressions undertaken) were guided by the primary research questions (reiterated below). No prior findings or theory were available, so no pre-selection of independent variables was undertaken and all variables were included in the models unless the number of observations was inadequate. Variables were not included if less than 10% of the responses were recorded in any one category. Some variables were recoded into fewer categories. Variables excluded for 'insufficient variation' included housing tenure. As no inter-relationships between variables were assumed, so interaction on terms were not added to the model.

9.5 Characteristics of the samples and the problems of matching

9.5.1 Characteristics of the samples

This section presents the characteristics of the participants in the RRS and hospital samples in terms of their socio-demographic attributes, reasons for admission, background medical conditions, receipt of informal and formal care, and the involvement of various care professionals (or agencies) in their admissions.

Sex

Table 9.5.1 shows the number of male and female participants from the RRS and the hospital. The comparison hospital sample successfully reproduced the sex distribution of the RRS sample (χ^2 =0.22; d.f.=1; p=0.64).

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medical history, type of care received (RRS or hospital care scheme), sex, and receipt of care services.

Table 9.5.1 Sex of RRS and hospital patients (frequencies)

Sex	RRS	Hospital	Total
Male	57	62	119
Female	93	88	181
Total	150	150	300

Ages and age groups

There was no significant difference in the distribution of the two sets of respondents by three 10-year age groups (Table 9.5.2). An independent-sample *t*-test that compared the average age for RRS and hospital patients found however a significant difference.[2] As shown in Figures 9.5.1 and 9.5.2, the selected hospital patients were about twice as likely as RRS patients to be aged 70-79 years. On the other hand, RRS patients were 1.6 times more likely to be aged 80-94 years than hospital patients. The imbalanced age distribution between RRS and hospital patients will be discussed further in the following section.

Table 9.5.2 Age groups of RRS and hospital patients

Age groups (years)	RRS patients no	Hospital patients no	Total No
65-74	29	43	72
75-84	69	67	136
85+	52	40	92
Total	150	150	300

Note: Test statistics: χ^2 =4.32; d.f.=2; p=0.12

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[2] RRS patients mean=81.4 years, s.d.=7.12; hospital patients mean=79.1 years, s.d.=6.95, t(298)=2.87, p=0.004, 95% confidence interval=0.73-3.93.

Figure 9.5.1 Age of RRS patients

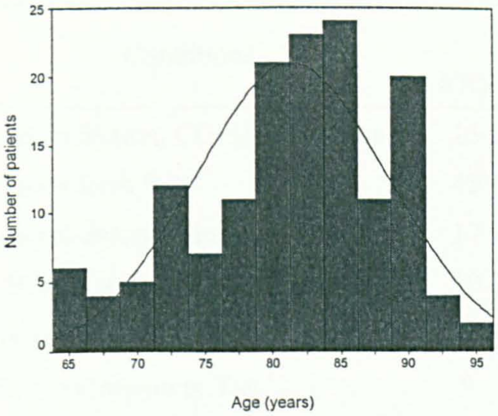
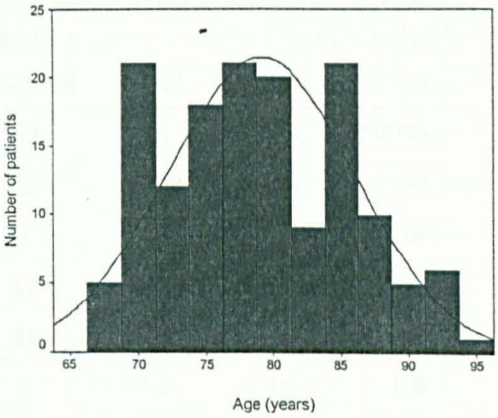


Figure 9.5.2 Age of hospital patients



Reasons for admission

The similarities and differences of the two groups of sample patients in terms of main health problems were explored. The three most frequent main health problems in both patient groups were respiratory problems (such as chest infection, chronic obstructive pulmonary disease or asthma) falls, and 'general deterioration'. More specifically, the most frequent main problems of RRS patients were mobility limitations, injuries following falls, and respiratory problems. On the other hand, the most frequent problems of hospital patients were respiratory problems followed by injuries from falls. The proportions of RRS and hospital patients admitted due to respiratory problems, falls and for pains were significantly different (Table 9.5.3). In general, hospital patients were likely to require more medical interventions than RRS patients, while the RRS patients were likely to require more care for mobility limitations.

The next most important reasons for admission in both patient groups were general deterioration, the need of support, or changed caregiver's circumstances (RRS patients n=93, 66.9%; hospital patients n=56, 45.2%) (Table 9.5.4). More RRS patients presented with social care needs arising from a change in a caregiver's circumstances and with more severe medical or physical deterioration conditions than hospital patients.

Table 9.5.3 The first reason for admission

Conditions	Frequencies			Chi-squared results	
	RRS	Hospital	Total	X^2	p value
Chest infection, COPD, or asthma	23	62	85	23.71	0.001
Injuries from falls[a]	48	25	73	8.76	0.003
General deterioration (not coping)	17	7	24	3.67	0.06
Infection on leg	10	11	21	0.001	1.0
Urinary-tract infection	10	10	20	0.001	1.0
CVA[b] extension or TIA[c]	9	10	19	0.001	1.0
Heart failure	5	8	13	0.32	0.57
Pain in the knee, leg, hip, or back	11	2	13	5.15	0.02
Diabetes[d]	4	8	12	0.78	0.38
Other reasons[e]	13	7	20	1.34	0.25
Total	150	150	300		

Notes: a. Includes mobility problem or injury except bone fracture; b. Cerebrovascular accident; c. Transient ischaemic attack; d. Includes ulcer on foot, for insulin therapy, collapse due to hypoglycemia; e. Includes bowel problem, blood pressure monitoring and palliative care; The tabulated probability of no association uses Yates' Correction for Continuity. There was one degree of freedom for all the comparisons.

Table 9.5.4 The second reasons for admission

Conditions	Frequencies		
	RRS	Hospital	Total
General deterioration, the need of support, Changed caregiver's circumstances	93	56	149
Heart failure	3	19	22
Urinary-tract infection	8	6	14
Chest infection, COPD[b], or asthma	6	7	13
Blood pressure monitoring	5	8	13
Other problems[a]	24	28	52
Total	139	124	263

Notes: a. Include cerebrovascular accident extension, depression, infectious diarrhoea, and diabetes; b. Chronic obstructive pulmonary disease. There were 37 missing cases.

Medical history

The similarity and difference of the two groups of sample patients in terms of their medical histories were also examined. The three most prevalent histories of both sets of patients were heart disease, blood pressure problems, and cerebrovascular accident

(CVA) or transient ischaemic attack (TIA). The proportions of RRS and hospital patients with chronic obstructive pulmonary disease (COPD) and falls were significantly different. Hospital patients were more likely to have COPD than RRS patients, but RRS patients were more likely to have a history of falls (Table 9.5.5). Overall, the hospital patients tended to have medical histories involving more intensive medical interventions, while the RRS patients tended to have histories requiring more care for mobility limitations (as both causal factors and sequela of falls).

Table 9.5.5 Medical history

Medical history	Frequencies			Chi-squared results[b]	
	RRS	Hospital	Total	X^2	p value
Heart disease[a]	51	69	120	2.52	0.11
Blood pressure problems	27	41	68	2.38	0.12
CVA or TIA	34	22	56	3.42	0.07
COPD	13	41	54	14.86	0.001
Falls	35	8	43	20.31	0.001
Diabetes	17	25	42	0.90	0.34
Cancer	25	14	39	3.75	0.05
Chest infection	15	15	30	0.001	1.00
Asthma	10	19	29	1.98	0.16
Hip replacement	11	6	17	1.29	0.26
Urinary-tract infection	7	6	13	0.01	0.91
Total	138	147	285		

Notes: Total missing n=15 (RRS=12; Hospital=3); a. Includes failure and ischaemic heart disease; b. The tabulated probability of no association uses Yates' Correction for Continuity. There was one degree of freedom for all the comparisons.

Utilisation of formal and informal care services

The similarities and differences of the two groups of sampled patients in terms of their prior contacts with health and social services were also examined. The most commonly used formal care services by both patient groups were the social services network alarm (or warden equivalent), district nurses, and the home-care social service. The use of home care, day care, home help, installed-alarm (or warden) service, and chiropodist services were significantly different. RRS patients were generally more likely to use care services than hospital patients (Table 9.5.6). The main reason would be because they were frailer and had more chronic disabled conditions than hospital patients. On the other hand, there was no significant difference in the availability of informal caregivers between the two patient groups. More than two-third of patients had an informal caregiver(s). For both patient groups, among the carers, 46%, 22% and 32% respectively informal caregivers were daughters, spouses (or partners), and other relatives (or friends).

Table 9.5.6 The receipt of formal and informal care by RRS and hospital patients

Formal or informal care	Frequencies			Chi-squared results[b]	
	RRS	Hospital	Total	X^2	P
Formal care					
Home care (social service)	67	29	96	20.97	0.001
Day care	28	11	39	7.67	0.006
Meals-on-wheels	20	10	30	3.07	0.08
Home-help[a]	28	13	41	5.54	0.0
Home loans	40	35	75	0.25	0.62
Neighbourhood support	9	5	14	0.68	0.41
Alarm installed or warden	74	46	120	10.17	0.001
Aids and adaptations	32	21	53	2.21	0.14
Transport service	11	9	20	0.05	0.83
District nursing	57	41	98	3.27	0.07
Heath visitor	18	8	26	3.45	0.07
Physiotherapy	11	4	15	2.49	0.12
Chiropodist	48	28	76	6.2	0.01
Informal care	110	116	226	0.33	0.57
Daughter	48	55	103	↓	↓
Spouse or partner	25	25	50	0.54[c]	0.76[c]
Other relative or friend	37	36	73	↑	↓

Notes: Total n=300 (RRS=150; Hospital=150); a private paid help; b. The tabulated probability of no association uses Yates' Correction for Continuity. There was one degree of freedom for all the comparison except the c results; c. Resulted from Pearson Chi-Square test. There were two degrees of freedom for the comparison.

Marital status and living arrangement

The differences of the two groups of sampled patients in marital status and living arrangements were also examined (because these attributes strongly correlate with the availability of informal carers and the need for formal care services). Among the combined patient groups, 64% were widowed, 28% were married, 7% were single, and 2% were divorced or widowed. The marital status distributions of the two patient groups were not significantly different (Table 9.5.7). On the other hand, the living arrangements were significantly different: 73% of RRS patients lived alone, but only 59% of the hospital patients. Hospital patients (14%) were also much more likely than RRS patients (3%) to live with persons other than a spouse (Table 9.5.8).

Table 9.5.7 Marital status and living arrangements

Marital status	RRS	Hospital	Total
Married	39	44	83
Single, divorced or widowed	111	106	217
Total	150	150	300

Notes: Yates' Correction for Continuity test (χ^2 =0.33; d.f.=1; p=0.57).

Table 9.5.8 Living arrangements of the RRS and hospital samples

Living arrangements	RRS	Hospital	Total
Living alone	109	88	197
Living only with spouse or partner	36	41	77
Live with other person[a]	5	21	26
Total	150	150	300

Notes: a. Includes living with other person (not a spouse or partner) and in a care home as permanent resident; Pearson Chi-Square test (χ^2 =12.4; d.f.=2; p=0.002).

Admission by the agency or professionals

The difference of the two groups of sampled patients in terms of referral agency (or profession) was also examined to throw light on the views of various care professions about the respective roles of the RRS and hospital care. As shown in Table 9.5.9, RRS patients were 2.5 times more likely than hospital patients to have been admitted through GP referrals, while not surprisingly hospital patients were three times more likely than RRS patients to have been admitted through hospital A&E.[3] The significant difference in the referrals by GPs and other care professionals might indicate that the

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[3] No statistical test was conducted on the association between three types of referral agency (or professions) because chi-square requires a minimum 'expected' cell frequency of 5 or greater (or at least 80% of cells have expected frequencies of 5 or more) (Pallant, 2001). Referrals by hospital staff and other primary health social care professionals were merged, and Yates' Correction for Continuity test for a 2 by 2 table was carried out. This found a significant difference in the referrals by GPs and other care professionals ($\chi2$ =49.69; d.f.=1; p=0.0001).

GPs did not consider the RRS as a substitute of hospital care but rather as a care service for a group of older people with specific care needs but who did not require the care available at the hospital.

Table 9.5.9 Referral agency or professionals

Agency or profession	RRS n (%)	Hospital n (%)	Total n (%)
GP	108 (72%)	37 (29%)	145 (52%)
A&E or admission ward	34[1] (23%)	90[2] (70%)	124 (45%)
Primary health and social care professional	8 (5%)	1 (1%)	9 (3%)
Total	150	128	278

Note: Hospital missing n=22; 1. A&E n=30 and admission ward n=4; 2. A&E n=90 (admission ward n=0).

9.5.2 The problems of matching RRS and hospital samples

Some significant differences in medical condition and care needs were identified between the RRS and the hospital patients, and found that RRS patients were on average older than hospital patients. There were approximately twice the number aged 80-94 years in the RRS than in the Hospital sample, whereas the Hospital sample recruited twice the number aged 70-79 years.

It was not possible to achieve an exact match by age because of the limited time and resources of this study. So few patients in advanced old age were being admitted to the BDGH that it would have required a very extended study to replicate the age distributions more precisely. In the event, it took 18 months to finish the data collection of this study. Consequently, patients who met the other inclusion criteria of this study including broadly defined age groups were recruited from the Hospital. The age difference between the RRS and hospital samples may reflect a true age difference between the two patient groups. It was concluded that there was strong empirical evidence of not only an age difference but also that the RRS was providing a different (and unprecedented) service for specific groups of older people, rather than providing a service that was a direct alternative to hospital for a single group of patients.

In support of this proposition, among the various reasons for admission, respiratory problems, falls and pain had significantly different frequencies between RRS and hospital patients. This finding suggests an actual difference of medical conditions between the two sets of patients. As mentioned in Chapter 8, patients who needed medical intervention were less likely to be referred to the RRS, but patients who needed care rather than cure were more likely to be referred to the RRS. Although all patients who gave consent to participate were recruited from the RRS and hospital, it therefore appears that admissions to the RRS and the hospital were different. RRS patients were more likely to have a medical history of falls due to mobility problems, while hospital patients were more likely to have a medical history of COPD. In addition, the significant difference in the *Activities of Daily Living* (ADL) and *Instrumental Activities of Daily Living* (IADL) scores between the two patient when controlled by the 10 year age groups clearly indicates that RRS patients were frailer and had more 'functioning problems' due to chronic conditions (Table 9.5.10).

Table 9.5.10 Difference in the mobility of RRS and hospital patients by the age groups

Age groups (yrs)	Measure	Mean (s.d.)		*t*-test	
		RRS	Hospital	*t* (df)	*p*
65-74	Barthel index	65.9 (29.2)	85.5 (17.8)	3.2 (42)	0.002
	IADL index	7.7 (4.3)	11.0 (3.3)	3.7 (70)	0.0001
75-84	Barthel index	72.1 (21.7)	84.8 (16.1)	3.9 (125)	0.0001
	IADL index	7.7 (3.9)	10.5 (4.0)	4.1 (134)	0.0001
85+	Barthel index	71.6 (19.0)	77.4 (22.5)	1.3 (90)	0.19
	IADL index	6.6 (3.2)	8.9 (4.5)	2.7 (66)	0.008

Note: Total n=300; Age group 65-74 years: RRS=29 and Hospital=43; 75-84 years : RRS=69 and Hospital 67; 85+ years: RRS=52 and Hospital 40. More severe problems produce lower Barthel and IADL scores.

The evidence from the availability of formal and informal care before admission to RRS or hospital adds weight to the proposition of category differences between RRS and hospital patients. There were significant differences in the receipt of home care, day care, home help, alarm installed or warden service, and chiropodist services. RRS patients were significantly more likely to have been using all those services. Living arrangements were also different between RRS patients and hospital patients. RRS patients were significantly more likely to live alone, while hospital patients were more likely to live with a spouse, partner or other person(s). Living arrangements are closely associated with the availability of an informal carer, and it is clear that RRS patients were less likely to have an available informal carer and more likely to need the services of formal carers.

It has been concluded, that when constructing the comparison samples, some differences in the age distribution and the reasons for admissions between RRS and hospital patients were unavoidable even though the patients were recruited by the same inclusion criteria. The populations of the two patient groups are different and have different care needs.

9.6 Main results from the comparison between RRS and matched hospital patients

The following results sections are structured according to the primary research questions. There are two main themes: the service outcomes and patients' satisfaction with the services. The service outcomes include duration of the care episodes, the patients' physical and emotional functioning on discharge, and their status 90 days after discharge. The service outcomes findings derive mainly from the quantitative data, except that the satisfaction indicators are also a product of the qualitative research.

A. Service outcomes

a) Were there differences between RRS patients and the hospital patients in: (a) the duration of care episodes, and (b) the physical and emotional functioning at discharge?

To find differences in the health status and the duration of care episode on discharge between the two sets of patients, independent *t*-tests of the mean scores on continuous variables were conducted. The outcome data about physical and emotional functioning were measured by the *Barthel*, *IADL*, and *Morale* indexes. There were significant differences in the three index scores and in the duration of care episodes (Table 9.6.1).

Table 9.6.1 Outcomes of care at discharge

Outcomes (total scores)	RRS Mean (s.d.)	Hospital Mean (s.d.)	*t*-test
Barthel index	70.7 (22.4)	83.0 (18.6)	*t*=5.2; d.f.=298; p=0.0001
IADL index	7.3 (3.8)	10.2 (4.0)	*t*=6.4; d.f.=298; p=0.0001
Morale Index	7.0 (4.0)	8.0 (3.6)	*t*=2.3; d.f. =297; p=0.02
Duration of stay (days)	11.0 (4.1)	13.0 (7.3)	*t*=2.9; d.f. =296; p=0.004

As mentioned earlier, although there was no significant difference in the 10-year age groups between the two groups of patients, there was a significant difference in the mean ages. Logistic regression analyses were therefore conducted to explore whether the age difference significantly affected the service outcomes of the RRS and hospital patients. Two independent variables, age and care scheme (RRS or hospital) were input as independent variables or factors to predict the outcomes at discharge (Barthel, IADL and Morale scores) and the duration of care episodes. The regressions found that the type of care scheme significantly related to the Barthel and Morale index total scores and the duration of care episode (Tables 9.6.2, 9.6.4 and 9.6.5). Types of care scheme and age also significantly predicted IADL score (Table9.6.3). Age did not however significantly affect the Barthel and Morale scores at discharge and the duration of care episode. These results suggest that it may be appropriate to disregard IADL scores at discharge when comparing RRS and hospital care.

Table 9.6.2 Linear regression for the Barthel index total scores at discharge by age and type of care

Independent (predictor) variables	Beta	Standardised β coefficient	95% CI for β	*P*
Type of care*	12.27	0.29	7.58-16.95	P<0.001

Notes: * RRS or hospital care; Adjusted R^2 =0.079; F=26.54; df=1; Age was excluded from the final model; CI (confidence interval).

Table 9.6.3 Linear regression for the IADL index total scores at discharge by age and type of care

Independent (predictor) variables	Beta	Standardised β coefficient	95% CI for β	*P*
Type of care*	-0.08	-0.13	-0.14- -0.01	0.02
Age	2.72	0.33	1.83-3.61	0.0001

Notes: * RRS or hospital care; Adjusted R^2 =0.133; F=23.86; df=2

Table 9.6.4 Linear regression for the Morale index total scores at discharge by age and type of care

Independent (predictor) variables	Beta	Standardised β coefficient	95% CI for β	*p*
Type of care*	1.03	0.14	0.16-1.89	0.02

Notes: * RRS or hospital care; Adjusted R^2 =0.015; F=5.49; df=1; Age was excluded from the final model.

Table 9.6.5 Linear regression for the duration of care episode by age and type of care

Independent (predictor) variables	Beta	Standardised β coefficient	95% CI for β	*P*
Type of care*	1.97	0.17	0.63-3.31	0.004

Notes: * RRS or hospital care; Adjusted R^2 =0.024; F=8.36; df=1; Age was excluded from the final model.

b) Were differences in discharge destination, readmissions, falls and mortality at 90 days after the care episode between the RRS patients and the hospital patients?

Chi-squared tests were conducted to identify the differences between the RRS and hospital samples in terms of: admissions to hospital or a care home as a permanent resident, falls, and deaths within 90 days of discharge. It is useful to compare the four outcomes and sequelae between the two sets of samples, because these outcomes are indicators of whether the care received met the needs of the service users. RRS patients were significantly more likely than hospital patients to be admitted to a care home as a permanent resident (Table 9.6.6). RRS patients were also more likely to be readmitted to hospital, to fall and to die, although the differences with hospital patients were not statistically significant.

Table 9.6.6 Outcomes and sequelae within 90 days of discharge

Outcomes and sequelae	RRS	Hospital	Chi-squared test*	
	N (%)	n (%)	X^2	*p*
1) Readmission to hospital	40 (28.8)	38 (27.7)	0.003	0.95
2) Fall	15 (20.0)	10 (12.3)	1.2	0.28
3) Admission to a care home	25 (18.2)	12 (8.6)	4.7	0.03
4) Death	25 (17)	22 (15.1)	0.1	0.77

Note: Total n=300; RRS=150; Hospital=150; Missing n: 1) RRS=11; Hospital n=13; 2) RRS n=75; Hospital n=69; 3) RRS=13; Hospital n=11; 4) RRS=3; Hospital=4; * Result from Yates' Correction for Continuity. There was one degree of freedom for all the comparisons.

c) Were differences in increases in service uses by 90 days after discharge between the RRS patients and the hospital patients?

Chi-squared tests were conducted to identify the differences in increased service use between RRS and hospital samples after 90 days of discharge. It would be valuable to compare the increased service use between the two sets of samples, because new services indicate that effective assessments have been made of patients' needs. Differential referrals to community health and social services may also indicate the relative dependency of older patients with long-term disabled conditions. RRS patients were generally more likely to be referred to and to use community health and social care services following discharge. They made significantly more use than hospital patients of respite care, home-delivered meal services and neighbourhood support services (Table 9.6.7). RRS patients were also more likely than hospital patients to be referred for aids and adaptations, although the result was not statistically significant.

Table 9.6.7 Increased service use within 90 days

Care services	RRS		Hospital		Statistical test[a]	
	Increased	The same or less	Increased service	The same or less	X^2	p
Home care	12	62	7	77	1.63	0.20
Respite care	15	59	5	79	6.06	0.01
Meals delivered Service	9	65	1	83	6.25*	0.006*
Aids and Adaptations	14	60	7	70	2.96	0.09
Physiotherapy	8	66	4	79	1.23	0.27
Neighbourhood Support	5	69	0	84	3.86*	0.02*
Day care	5	69	3	81	0.3*	0.48*
Home help	10	64	6	78	1.12	0.29
Home loans	25	47	20	64	1.75	0.19
Alarm system Installed	7	67	6	78	0.06	0.81
District nursing	7	67	9	75	0.0001	1.00
Health visitor	8	66	6	78	0.28	0.60
Chiropodist	6	68	13	71	1.38	0.24

Notes: Total n=300 (RRS=150 and Hospital=150), Total missing n=142 (RRS=76 and Hospital=66); a. Yates' Correction for Continuity except the * marked results.; * Fisher's Exact Test that used instead of chi-squared when the expected frequencies are less than 5 in the 2 by 2 table. There was one degree of freedom for all the comparisons.

d) What is the best predictor of the duration of a care episode?

Logistic regression was conducted to identify the factors that associated with the duration of a care episode. These analyses found that four factors significantly predicted duration of more than seven days (Table 9.6.8). Patients with low morale scores were significantly more likely to stay on the care scheme for long durations. Patients who expressed dissatisfaction with the privacy of the care arrangements were significantly less likely to stay on the care scheme over seven days than patients who didn't. Patients who expressed dissatisfaction with medical treatment were about six times more likely to stay on the care scheme over seven days than patients who didn't. Patients who used the health visitor service before they were admitted to the care scheme were only 0.06 times as likely to stay on the care scheme over seven days than patients who didn't.

Table 9.6.8 Logistic regression estimation for likelihood of the care episode exceeding seven days

Predictor variables	Category	Odds ratio	95% Confidence interval	*p*
Morale index total	Score (0-5)	8.3	2.26-30.57	0.001
Scores	Score (6-11)	4.6	1.61- 13.18	0.004
Expressing dissatisfaction with respected privacy	Yes	0.07	0.02 – 0.29	0.0001
Expressing dissatisfaction with medical treatment	Yes	6.0	1.02 – 34.71	0.047
Use of health visitors	Yes	0.06	0.01 – 0.31	0.001

Note: The duration of care was categorised to a dichotomy (1-7 days and 8+ days) to run binary logistic regression.

e) What is the best predictor of the patient being admitted to a care home as a permanent resident within 90 days following the care episode?

Logistic regression was conducted to identify the multivariate factors that associated with being admitted to a care home as a permanent resident within 90 days of discharge. These analyses revealed six factors that significantly predicted being admitted (Table 9.6.9). Patients who were admitted to the RRS due to general deterioration were nine times more likely than other patients to be admitted to a care home as a permanent resident within 90 days of discharge (p=0.023). Patients who expressed dissatisfaction with the facilities or environment of the care scheme were 15 times more likely to be admitted to a care home as a permanent resident than patients who did not express dissatisfaction.

Patients who used home care service before admission to the care scheme were 4.7 times more likely to be admitted to a care scheme as a permanent resident than patients who didn't. Married patients were significantly less likely to be admitted to a care home than single, divorced or widowed patients (OR=0.8; 95% CI=0.01-0.63; p=0.02). Patients whose IADL scores were in the range 0-6 were 6.6 times more likely to be admitted to a care home as a permanent resident than those with scores in the range 12-16 (p=0.03).

Table 9.6.9 Logistic regression estimation for likelihood of being admitted to a care home as a permanent resident within 90 days following the care episode

Predictor variables	Category	Odds ratio	95% Confidence interval	*p*
Reason for admission: General deterioration	Yes	8.6	1.3 – 55.1	0.023
Expressing dissatisfaction with the facilities	Yes	14.7	3.0 – 70.5	0.001
Expressing dissatisfaction with environment	Yes	5.2	1.1 – 26.0	0.04
Use of home care service	Yes	4.7	1.1 – 19.3	0.03
Marital status	Married	0.08	0.0 – 0.6	0.02
IADL index total scores	Score (0-6)	6.6	1.3 – 34.7	0.03
	Score (7-11)	0.9	0.2-5.2	0.92

f) What is the best predictor of the patient being readmitted to an acute hospital within 90 days of the care episode?

Logistic regression was conducted to identify the factors that were associated with being readmitted to an acute hospital within 90 days of discharge. These analyses identified two significant factors (Table 9.6.10). Patients who had a medical history of ischemic heart disease were 2.4 times more likely to be admitted to hospital within 90 days (p=0.03). Patients with a medical history of deep vein thrombosis (DVT) were 13.8 times more likely to be admitted to hospital after the care episode (p=0.046).

Table 9.6.10 Logistic regression estimation for likelihood of being readmitted to an acute hospital within 90 days of the care episode

Predictor variables	Category	Odds ratio	95% Confidence interval	*p*
Medical history: Ischemic heart disease	Yes	2.4	1.1 – 5.2	0.03
Medical history: DVT*	Yes	13.8	1.1 – 180.0	0.046

Note: * Deep vein thrombosis

g) Predictors of patient deaths within 90 days of a care episode?

Logistic regression was conducted to identify the factors that associated with mortality within 90 days of discharge. These analyses identified four significant factors (Table 9.6.11). Patients who had lower IADL scores (7-11) were 4.5 times more likely to die than patients who had scores in the range 12-16. Male patients were 3.3 times more likely to die than female patients (p=0.03). Patients who admitted to the care scheme due to heart failure were 10.5 times more likely to die than others within 90 days of discharge. Patients who expressed dissatisfaction with food were 4.4 times more likely to die within 90 days than patients who did not (p=0.01).

Table 9.6.11 Logistic regression estimation for likelihood of a patient's death within 90 days of a care episode

Predictor variables	Category	Odds ratio	95% Confidence interval	*p*
IADL scores	0-6	3.5	0.7-17.0	0.12
	7-11	4.5	1.0 – 19.7	0.04
Sex	Men	3.3	1.1 – 9.6	0.03
Reason for admission: heart failure	Yes	10.5	1.2 – 90.9	0.03
Expressing dissatisfaction with food	Yes	4.4	1.4 – 13.7	0.01

B. The patients' satisfaction of the service use

a) Did the RRS patients and hospital patients have significantly different views of satisfaction with the service they received?

Quantitative data analyses

'Satisfaction with care' has long been considered as a care outcome. It would be therefore valuable to identify the difference in satisfaction between the two samples. A chi-squared test was conducted to explore the difference. The RRS patients were significantly more satisfied with respect for privacy, and significantly more dissatisfied with medical treatment. Although the results were not statistically significant, RRS patients were more likely to have been satisfied with the follow-up care service arrangements and with communication with staff (Table 9.6.12).

Table 9.6.12 Patients' satisfaction at discharge

	Satisfied				Dissatisfied			
Feature of care	RRS n (%)	Hosp n (%)	All n	*p*	RRS n (%)	Hosp n (%)	All n	*p*
Staff attitude	99 (66)	109 (73)	208	0.3	7 (5)	10 (7)	17	0.6
Medical Treatment	66 (44)	105 (70)	171	0.001*	45 (30)	13 (9)	58	0.001*
Environment for Recovery	76 (51)	66 (44)	142	0.3	12 (8)	16 (11)	28	0.6
Quality of food	30 (20)	45 (30)	75	0.1	27 (18)	27 (18)	54	1.0
Near to home or Family	34 (23)	24 (16)	58	0.2	27 (18)	12 (8)	39	0.09
Convenient Facilities	27 (18)	19 (13)	46	0.4	31 (21)	33 (22)	64	1.0
Follow-up care Service	25 (17)	13 (9)	38	0.1	103 (69)	103 (69)	206	1.0
Respecting Privacy	22 (15)	9 (6)	31	0.02*	19 (13)	10 (7)	29	0.3
Clear communication	19 (13)	12 (8)	31	0.2	63 (42)	84 (56)	147	0.1

Notes: Total n=300: RRS n=150; Hospital n=150; Respondents were asked to identify the two or three most satisfactory and dissatisfactory aspects of care from 9 features of care; P values were derived from Yates' Correction for Continuity which compensates for the overestimate of the chi-square value when used with a 2 by 2 tables; * $p<0.05$

9.7 Analysis of the responses to the open-ended questions

Responses to the open-ended questions on the satisfaction questionnaire administered during the face-to-face interviews provided evidence of 'other' factors that caused satisfaction or dissatisfaction. The first step in the analysis was to read through the transcripts and to code sections of text into analytical categories. Following the procedure recommended by Dey (1993), sections of data were referred to as *databits* (a word or two, a phrase or a sentence). This process identifies primary categories which are then grouped into themes. Following the procedure described by Bowling (2000), a content analysis was then carried out, by which the whole data set was searched for the identified categories. Intensive and repeated comparisons were made to discover similarities or differences between the two main groups of respondents (RRS and hospital patients) in the study.

As shown in Tables 9.7.1 and 9.7.2, among the themes that expressed satisfaction, only one had similar prevalence among both patient groups, and all other themes were articulated only by the RRS patients. Among the eight themes of dissatisfaction, three had similarly prevalence in both patient groups, four were expressed only by RRS patients, and one only by hospital patients.

Table 9.7.1 Expressions of satisfaction with care by RRS and hospital patients

	RRS	Hospital
Similar	➢ Good relationship with staff	➢ Good relationship with staff
Different	➢ Being treated in a home or home-like environment ➢ Respite care or support ➢ Rapid response to needs ➢ Additional care after hospital stay ➢ Quick access to social service or Good follow-up care	➢ Environment for recovery (clean and better compared to the past)

Table 9.7.2 Expressions of dissatisfaction with care by RRS and hospital patients

	RRS	Hospital
Similar	➢ Facilities, equipment or material supplies ➢ Environment for recovery ➢ Lack of communication	➢ Facilities, equipment or material supplies ➢ Environment for recovery ➢ Not clear communication
Different	➢ Inappropriate medical aspects of care ➢ Insufficient caring ➢ Limited or short duration of care	➢ Long waiting time ➢ Difficult access to GP

The following paragraphs present examples of the patients' comments and expressions. They are organised by the 'themes' listed in the above Tables.

A. Features of care of being satisfied by RRS and hospital patients

Good relationship with staff (RRS and hospital patients)

Good relationships with the care staff was a common feature of the patients' expression in both groups, as evidenced by the following quotes:

> Everyone who dealt with me, from the ambulance men to the doctors, nurses, catering staff and cleaners were all excellent. No one could have done any better they were all first class (Hospital patient).

> The respect from the Rapid Response Team in Barnsley is first class. They are truly 'guardian angels' [and] their kindness has no boundaries. Its really a pity that their care could not continue indefinitely (RRS patient).

> Everyone has been marvellous and caring and very kind, helpful, polite and very friendly. I cannot praise them enough for their tender care, kindness and excellent help (RRS patient).

Being treated in a home or home-like environment (RRS patients)

Being treated at the patient's own home, at the primary care resource centres or in a residential or nursing home, all of which are environments that are more home-like than the hospital generated satisfaction among the RRS patients. In particular, patients who had had bad experiences during a hospital stay were pleased to be treated at their own home or in a care home. The following expressions from the interviews illustrate the satisfaction of being treated at home or in a home-like environment:

> It's more personal and much better than hospital care.

> Being in hospital is boring. I preferred to be at home. I don't like hospital food and the smell of food in the hospital. I don't like the hospital beds and toilets. I don't like to be around sick people.

> The after-care at home was very good.

Environment for recovery: clean and better compared to the past (Hospital patients)

Some hospital patients expressed satisfaction with the hospital environment, by making comparisons with the past:

> This is my 35th stay in hospital and would like to stress [for you] the immense change for the better since my first stay in 1947.

> Compared with ten years ago, the ward is cleaner and the staff are kinder. [It's] very much improved.

Respite care or support (RRS patients)

Some RRS patients were satisfied with the service because it provided unexpected support or help, and some were satisfied with the free personal care or respite care, as evinced by the following quotes:

> I have been totally satisfied with the service I received during my stay at Highfield Grange [a resource centre operated by Barnsley social services which provides limited beds and care for the RRS].

> We are all very grateful for help we have had and we could not have managed without them.

> The Rapid Response Team is the first home-care service I have received during my illness and I cannot praise them enough for their tender care.

> Without their help, I could not have coped.

Rapid response to the need (RRS patients)

Some RRS patients found satisfaction in the service's quick response to their needs, as compared to hospital care or other health and social services. The following quotations illustrate this theme:

> The immediate action was taken to help my recovery.

> The 6 hours wait at hospital was disgusting for me. I am 92 years old. But this had nothing to do with Rapid Response Team. There were excellent when they came.

> The rapid response team's initial response was excellent.
>
> The rapid response service was just that – they provided very good help when urgently needed.
>
> I had spent six hours in A&E waiting for a bed. Within two hours of the RRS coming, I was found a bed in a nearby nursing home for three nights.
>
> They [RRS team] were only a phone call away,. and whenever I needed them they came. They truly live up to their name 'Rapid Response'.

Additional care after hospital stay (RRS patients)

Some RRS patients were satisfied with the team's organisation of follow-up care (convalescent care) after their hospital stay, as evinced by the following quotes:

> I was well treated at hospital and afterwards at home by carers over the seven days that they came.
>
> I was very ill in hospital and could not get to know what was wrong. After my hospital stay, the Rapid Response Service was very good during the short time they came.

Quick access to social service or good follow up care (RRS patients)

Some RRS patients needed support and care from social services but had been unable to access the service. They were satisfied with the quick assessment and the care provided by the RRS, as shown in following quotes:

> Neither myself or my husband has ever needed any sort of help or care before, but now we do. They have been marvellous and caring … We all very grateful for the help we have had and we could not have managed without them.
>
> They [RRS team] were my guardian angels. The social worker appointed to our case, well, the least said the better. She let us down very badly and was never available when we needed her, but as I say, the least said.

B. Features of care that caused dissatisfaction among RRS and hospital patients

Facilities, equipment or material supplies (RRS and hospital patients)

Inconvenient facilities and insufficient equipment and material supplies were common sources of dissatisfaction for both RRS and hospital patient groups. Compared to the RRS patients, hospital patients were more likely to express dissatisfaction with inconvenient toilet facilities (including commodes for the disabled) as seen in the following quotes:

> Being a non-smoker, I would like a dayroom for non-smokers (Hospital patient).
> They [staff] did not let me have a commode chair but I need to have one this time [evening and night time]. It is very hard for me to walk to the toilet because I am breathless (Hospital patient).

> The toilet facility is very old and inconvenient for me. The money is going to the big hospitals and not being distributed to the district hospitals. The money should come here. There is no café for patients and visitors (Hospital patient).

> I was satisfied with all the treatment received with the exception of insufficient pads for my complaint [incontinence] (RRS patient).

Environment for recovery (RRS and hospital patients)

The environment of care commonly produced dissatisfaction among both RRS and hospital patient groups. Some in both groups were dissatisfied with the impersonal care. For example, the stipulated early bedding and dinner times were complained about by both patient groups and seen as for the convenience of the service provider. On the other hand, some hospital patients didn't like to be in the hospital without good cause. Being admitted to hospital may be traumatic for some older patients, and some were receiving care rather than treatment, investigations or scans. Similarly, some RRS patients found that living with the mentally disabled and critically ill people in the nursing home was unpleasant, as expressed by the following quotes:

> It was very hard for me to go to bed earlier than my usual sleeping time (Hospital patient).

> It does not mean that I am not happy here, but I would like to be in the home where there are more normal people and it is more comfortable (Hospital patient)

> I would like to go home at the weekend. Nothing does for me on weekends. It's just a waste of time (Hospital patient).

> I like to stay home. It is very traumatic [being in hospital]. I didn't know what was happening to me in this hospital (Hospital patient).

> The dinner time in this home is at half-past-four, and breakfast time is at half-past-eight, so I am starving at night (RRS patient).

> Overall the standard of care I received was quite good, but at times I found it difficult to cope with the other residents in the nursing home. I have no mental problems but I had to cope with patients suffering from dementia, who were wandering and shouting, and with some patients who at times were very seriously ill. I found it was hard to cope with. After the initial fortnight, I was transferred to the residential section of the home where I was able to settle better (RRS).

Lack of communication (RRS and Hospital patients)

Poor communication with the staff was a common source of dissatisfaction in both patient groups, although the complaints from the two groups were slightly different. Hospital patients were likely to complain about communication between the patient and care provider, but RRS patients were likely to complain about communication between the RRS team and other care professionals or informal carers and about communication among the RRS team members, as evinced by the following quotes:

> I don't know what is wrong with me. I wasn't given information about my condition (Hospital patient).

> I had several X-rays and CT scans but nobody told me what they had found from the scans (Hospital patient).

> There appeared to be a lack of communication between the Rapid Response Team and the district nurse about my insulin injection times (RRS patient).

> A member of staff told me that I would be left on my own during the day for a couple of hours, but another staff member called and asked why I was on my own (RRS patient).

Inappropriate medical aspect of care (RRS)

Some RRS patients were dissatisfied with the medical aspects of their care, and others indicated a lack of support from the doctor during and after RRS care episode. In particular, some patients who were transferred to the acute hospital in the middle of the care episode expressed strong dissatisfaction with the medical aspect of RRS care. They were specifically concerned about the RRS capacity to provide medical care in the nursing home, in the following quotes:

> The treatment should be prior before coming into this care home.

> The Rapid Response Team's initial response was excellent and I was placed very quickly in Belle Green Nursing Home [a private home which provided beds and care for the RRS], but I have a serious concern about the medical care there. I deteriorated in the first week.

> The treatment from the Rapid Response Team was good and most welcome. I had spent six hours in A&E waiting for a bed. Within two hours of the RRS team coming, I was found a bed in a nearby nursing home for three nights, and then had to be transferred back to the hospital which, in my opinion, I should not have left as I was so ill.

Insufficient caring (RRS patients)

Among the RRS patients who received care at their own home, some were dissatisfied with insufficient care. They were usually visited by support workers and other qualified staff (nurse, physiotherapist and occupational therapist) from the RRS team during the day, but the several visits by the RRS team were for some not enough to meet the patients' needs, as expressed in the following quotes:

> There was insufficient concern shown about my general wellbeing.

> My specific illness was treated and monitored, but no attention was paid to my loss of appetite or to comfort pressure areas. Not enough interest was shown otherwise.

The limited or short duration of care (RRS patients)

As mentioned earlier, RRS provided a finite duration of care: seven days for patients receiving care at the patients' own home, and 14 days for patients receiving care in a residential or nursing home. Some RRS patients were dissatisfied with the short duration and discontinuity of care, as evinced by the following quotes:

> There was not enough time with the physiotherapist.

> I found it difficult in that we had different nurses at the start from the end. It would be very good if there could be some continuity.

Difficult access to GP (Hospital patients)

Some hospital patients complained about difficulties in accessing their GP, and mentioned that they were admitted to hospital for that reason, as evinced by the following quotes:

> I wanted a GP to see me when I was ill but one didn't come. So I came to A&E.

> A GP assessed me a long time ago when I was 70 years of age. Since then I always had the same prescription. That is why my condition worsened.

Long waiting time (Hospital patients)

Hospital patients were dissatisfied with the long waiting times to see a doctor, for a bed in A&E, and for prescribed medications, as shown by the following quotes:

> There's a shortage of staff. I had to wait for many things, especially medication. (Hospital patient).

> I had to wait for my medication for a long time but I can understand the problem with the shortage of staff (Hospital patient).

> The worse part in the hospital is A&E. I had to wait for a doctor for such a long time. I waited for about four hours (Hospital patient).

9.8 Discussion of findings and study limitations

9.8.1 Discussion of findings

This discussion of the findings is structured by the primary research questions of the study.

Research Question

A. Service outcomes

a) Were there differences between RRS patients and hospital patients in: (a) the duration of care episodes, and (b) their physical and emotional functioning at discharge?

To assess the differences in the patients' status on discharge and the duration of their care episodes between the two sets of patients, independent t-tests were conducted.

Significant differences were found in the Barthel, IADL and Morale scores and in the episode durations (Table 9.6.1). Furthermore, the findings from the logistic regression analyses indicated that the age difference between the RRS and hospital patients didn't significantly affect the service outcomes with the exception of the IADL index (Tables 9.6.2/3/4/5). Consequently, the IADL scores will not be used when comparing RRS and hospital care.

RRS patients were significantly more likely to have problems with activities of daily living (ADL) than hospital patients. Compared to a mean Barthel Index (BI) score for intermediate care patients of 79.8 on discharge from a nursing-led in-patient unit (Griffiths *et al.*, 2000), the mean BI score of the RRS patients at 70.7 was significantly lower. The mean age of the former group was 76 years, while the mean age of the RRS patients were 81.4 years. This shows that the RRS patients had worse ADL scores than matched Barnsley hospital patients or of one nurse-led intermediate care scheme. RRS patients may therefore have higher care needs associated with high dependency in the activities of daily living.

RRS patients were significantly less satisfied with life at discharge from the care scheme than hospital patients. The duration of care episode between RRS and hospital patients was significantly different (as a function of the RRS scheme's design). There are however other possible reasons. The shorter length of the RRS episode than the hospital stays may reflect the selection of hospital avoidance cases, or be a consequence of the rapid multi-disciplinary RRS team assessment. Overall, however, the findings strongly suggest that the two groups of patients have different care needs and different health status. If the RRS patients would otherwise have been admitted to hospital, then the RRS is successful hospital avoidance scheme. If not, RRS is not performing solely as an alternative to hospital care. Apart from saving some hospital admissions and bed-days, it can be argued that an important achievement of the RRS is to provide an assessment and care service to a previously under-served group of patients with chronic health and functioning problems. Perhaps the two issues (saving beds and meeting needs) should be dealt with separately and met by different types of care services.

b) Were there differences between the RRS patients and the hospital patients in discharge destination, readmissions, falls and mortality at 90 days after the care episode?

It would be valuable to compare the four outcomes and sequelae (admission to hospital or a care home as a permanent resident, falls, and death after 90 days of discharge) between the two sets of patients, because these outcomes indicate whether the care met the needs of the service users. Chi-squared tests were therefore conducted to compare the outcomes (Table 9.6.6). No significant difference was found between the two groups of patients in discharge destination, except that RRS patients were significantly more likely to be admitted to care homes at the three month follow-up.

As has been mentioned, RRS patients were significantly more likely to have a problem with mobility and this may have affected this result. Although there is no statistical confirmation, it was found through participant observation that the RRS patients who were positive about their care at a care home were more likely to stay in that home (or another) after the RRS episode. It would be useful if a future study established whether the positive experience of being in the care home encouraged the patients to decide on permanent residence, and how facilitating the decision to accept institutional residence affected the patients' long run quality of life.

c) Were differences in increases in service uses by 90 days after discharge between the RRS patients and the hospital patients?

It would be useful to compare post-care episode increases in service uses between the two sets of samples, because it may be a sign of either or both the effective assessment of patient needs and the frailty of older patients with long-term disabled conditions. Chi-squared tests were therefore conducted to discover the differences between the two groups in service use at 90 days from discharge. Significant differences between RRS and hospital patients were found in the use of respite care, home-delivered meals services, and the neighbourhood support service. RRS patients were broadly more likely to be referred to and to use many different health and social care services (Table 9.6.7). One exception was district nursing care.

These results reflect the greater frailty and dependence on others for ADL and IADL of RRS patients, and strongly support the finding that the rapid multi-disciplinary RRS team assessment provides quick access to health and social care support. The health and social care referrals may meet the specific needs of some older people, especially those with chronic disabling conditions. It may also save hospital beds, by avoiding subsequent admissions of the patients whose care needs are more comprehensively met after than before the RRS episode. A full evaluation of the 'hospital avoidance' effect of a RRS service requires an extended prospective or longitudinal design.

d) What is the best predictor of the duration of a care episode?

Logistic regression analysis was conducted to identify the factors associated with the duration of a care episode. These analyses established that four factors significantly predicted patients staying on the scheme for more then seven days (Table 9.6.8). Regardless of the type of care received (RRS / hospital), patients who were less satisfied with life were 4.6 times more likely to stay on the care scheme for more than seven days (although the 95% confidence interval for the estimate was large).

Patients who were dissatisfied with the respect shown for their privacy were significantly less likely than others to stay on the care scheme. A previous study by Brooker and Dinshaw (1998) indicated that staff and patients rated different aspects of service quality as important, and that older patients were generally less positive about their privacy than about the physical environment and standards of professional care. The present satisfaction study has found that both patient groups gave little weight to 'respect for privacy' in their evaluation of the quality of care. It was not anticipated that 'respect for privacy' would predict the duration of a care episode, although the result was statistically significant.

Patients who were dissatisfied with their medical treatment were about six times more likely to have a long stay (over 7 days) on the care scheme (although the 95% confidence interval for the odds estimate was large: 1.0 – 34.7). On the other hand, unmet medical care needs were hypothesised as associated with the duration of care, and the evidence supported the hypothesis. Patients who used the health visitor service before they were admitted to the care scheme were significantly less likely to experience the longer episodes of care. Among 13 formal home care services[4], however, the health visitor service was the fourth least frequently used service by both patient groups. Because there were few cases of RRS patients having been health visitor clients before being admitted to the scheme, it was not a strong predictor of the duration of care.

e) What is the best predictor of the patient being admitted to a care home as a permanent resident within 90 days following care episode?

A logistic regression equation was estimated to identify the factors associated with being admitted to a care home as a permanent resident within 90 days of discharge. The findings indicated that the type of care (RRS / hospital) was not a significant predictor

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[4] Include home care, day care, meals on wheel, home help, home loans, neighbourhood support, alarm installed or warden, aids and adaptation, transport service, district nursing care,

but six other factors were (Table 9.6.9). In both patient groups, those admitted due to general deterioration were 8.6 times more likely to be admitted to a care home as a permanent resident during the 90 days. According to Osato *et al.* (1993), 'general deterioration' is seen in patients with chronic or incurable illnesses, and the common signs included ADL changes, weight loss and anorexia. As the findings by Schroeder (1998) indicated, the decline of ADL performance and physical activity undermines the patients' confidence to live independently, and many decide to move to a care home. Not surprisingly, the level of independence in IADL was also a significant predictor of being admitted to a care home during the follow-up.

Patients who expressed dissatisfaction with the facilities or environment of the care scheme were significantly more likely to be admitted to a care home than others. These patients had most problems with chronic disabilities, and their needs were least well met by the facilities or environments of both care schemes (RRS / hospital). Subsequently, they were more likely to move to a long-term care facility which met their high needs. Marital status was a significant predictor of being admitted to a care home during the 90 days follow up. Being married was closely associated with the availability of informal care from a spouse. Single, divorced or widowed patients were more likely to be admitted to a care home than married patients.

f) What is the best predictor of the patient being readmitted to an acute hospital within 90 days of discharge from the care episode?

A logistic regression model was estimated to identify the factors associated with being readmitted to an acute hospital within 90 days of discharge. The findings indicated that the type of care (RRS / hospital) was not a predictor but two other factors were influential (Table 9.6.10). A medical history of ischemic heart disease was a strong predictor of being admitted to hospital during the follow-up. This finding contradicts the findings by Burns and Nichols (1991). According to them, among the independent variables[5] added to the model, diagnostic group (chronic obstructive pulmonary disease or chronic heart failure), emergency admission, and severity of illness were significant predictors of readmission to older people's or general medicine wards, but their findings also pointed out that readmitted patients had less ischemic heart disease. The second predictor of readmission to hospital was a history of deep vein thrombosis (DVT). However, the 95% confidence interval for the odds estimate was large because

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physiotherapy and chiropodist care and health visitor care.

[5] Including age, sex, social support, psychological and physical functioning, type of admission and clinical (diagnoses, type and source of year, illness severity).

the frequency of both patient groups (RRS / hospital) who had the medical history of DVT was very small (7 out of 300).

g) What is the best predictor of a patient's death within 90 days of a care episode?

A logistic regression was carried out to identify the factors associated with mortality within 90 days of discharge. The findings indicate that the type of care (RRS / hospital) was not a predictor of a patient's death during the 90 days follow up but four other factors were (Table 9.6.11). The patients' functional ability in IADL was associated with mortality during the 90 days following discharge, corroborating the findings of previous studies (Koyanon *et al.*, 1989; Bernard *et al.*, 1997; Scott *et al.*, 1997; Ginsberg *et al.*, 1999; Zanocchi *et al.*, 2001). Zanocchi (2001) found that impaired IADL among elderly patients was a strong predictor of six-month mortality after a hospital episode.

The second influential factor was the sex of the patient. Male patients were more likely to die within 90 days (RRS / hospital) than female patients. Further research is recommended to identify whether there other causal factors account for the differential mortality risk. Admissions with heart failure were significantly associated with mortality during the 90 days follow up. However, the 95% confidence interval could not be estimated because the frequency of both patient groups admitted with heart failure was too small (RRS: 5 out of 150: hospital: 8 out of 150).

The last identified factor, expressed dissatisfaction with food, is difficult to interpret. As discussed earlier, Greenley and Schoenherr (1981) found that patients with low expectations were less likely to be satisfied with the services they received, and patients with a low interest in food were likely to express dissatisfaction with food. As found by Nicolas *et al.* (2000), insufficient nutrient intake significantly preceded frailty, illness or death, and patients with low expectations about food were more likely to die during the follow-up. Accordingly, more study is recommended to distinguish low expectations and dissatisfaction with food during care episodes.

B. The patients' satisfaction of the service use

a) Did the RRS patients and hospital patients have significantly different views of satisfaction with the service they received?

Satisfaction with care has long been considered as a care outcome. It would therefore be useful to find the difference between two sets of samples in satisfaction with the care received. Chi-squared tests of data from pre-coded questions and the qualitative text were conducted to explore the differences. These show that the RRS patients were significantly more dissatisfied with the medical treatment received (Table 9.6.12).

According to Greenley and Schoenherr (1981), patients with low expectations have a low likelihood of being satisfied with the services they received. Several previous studies have indicated that patients are likely to be more satisfied with their care if their providers' behaviour corresponded to their needs (Lochman, 1983; Like and Zyzanski, 1987; Korsch, Gozzi, and Francis, 1968). The finding from this study that RRS patients were more likely to be dissatisfied with medical treatment may be associated with their lower need than hospital patients for medical interventions, or it may be because RRS patients received no or little medical treatment during the care episode regardless of their medical needs. The hospital patients would on the other hand have been more concerned about their medical treatment than the other features of care, for many had been admitted for a specific acute treatment or procedure. The different 'bases' of satisfaction are not therefore surprising.

RRS patients were significantly more satisfied with the level of respect for their privacy than hospital patients (Table 9.6.12). Many RRS patients received care at their own home or in a care home. The home or home-like environments may have increased the satisfaction of patients on this dimension.

Patients were asked to choose the three aspects of their care with which they were most satisfied and the three with which they were most dissatisfied. The relative frequencies for each feature of care are a useful indicator of the performance of the two services. Staff attitudes, medical treatments, and the environment for recovery were the three most frequently described satisfactory attributes, while follow-up care, clear communication, and inconvenient facilities were the three the most frequently described unsatisfactory attributes. These six features of care seem to be key aspects of meeting the care needs of older people. Both patient groups had similar satisfaction with staff attitudes and the environment for recovery. In contrast, follow-up care service and communication were found unsatisfactory by both patient groups (Table 9.6.12).

The findings from the qualitative data analyses indicate that both RRS and hospital patients were equally satisfied with their interactions with staff, and that some RRS and hospital patients were satisfied with the environment of care, but in different ways. Being cared for at the patients' own home, at a primary care resource centre or in a residential or nursing home was found satisfactory by the RRS patients, while some hospital patients were positive about the care environment when compared to the hospital's condition in the past (Table 9.6.13).

Some RRS and hospital patients were dissatisfied with the poor quality of personal care, particularly when this stemmed from the convenience of the service provider. Common instances include the very early bedding and meal times. In addition, some hospital patients did not like being in hospital for reasons they did not understand. Being admitted to hospital for some older patients who need only care or help, not an investigation or a scan, can be a traumatic experience. On the other hand, some RRS patients were dissatisfied with being placed for the first time in a nursing home where they were living alongside mentally disabled and critically ill people (Table 9.6.14).

Some RRS patients saw the scheme as providing unexpected support or help, and appreciated the unexpected free personal or respite care. Moreover, many of the patients who received the RRS after a hospital stay were also satisfied with the unexpected follow-up care. Some RRS patients were very satisfied with the literally rapid response of the RRS to their needs, and the way in which it provided quick access to social services and follow-up care.

Inconvenient facilities and insufficient equipment and material supplies caused dissatisfaction among both RRS and hospital patients. The hospital patients were more likely to express dissatisfaction with the toilets and prosthetic and aids equipment. Poor communication was complained about by the two groups in different ways. Hospital patients were dissatisfied with the communication between themselves and the care provider. RRS patients were more often dissatisfied with communication among the RRS team members, between the RRS team and other care professionals, and between the RRS team and their informal caregiver.

Inappropriate medical care prompted strong complaints by the RRS patients, especially among those who were transferred to the acute hospital in the middle of the care episode. Some patients wanted the GP to be more involved during and after the RRS care. Some patients were especially concerned about the capacity of the RRS team and the staff at the nursing home to provide medical care. Meanwhile, some patients who received the RRS at their own home complained about insufficient care. Many were visited by RRS staff (nurse, physiotherapist and occupational therapist) during the day but the visits were seen as inadequate to meet their needs. They wanted more attention to their general wellbeing and to chronic problems such as pressure care.

Some patients were very disappointed with the short duration of the RRS care. They were especially annoyed with the unavailability of continuing care, while others were dissatisfied by the multiplicity of staff that delivered the care during the short episode. Compared to the complaints by the RRS patients, hospital patients were noticeably dissatisfied with the difficulties of accessing their GP, the long waiting time to see a doctor, and the delays in being allocated a bed at A&E or in the administration of prescribed medications on the wards.

Overall, both patient groups were satisfied with the relationships with the staff, but dissatisfied with some care facilities and equipment, the impersonalised care environment, and poor communication. Compared to the hospital patients, RRS patients were satisfied with being treated at home or in a home-like environment, the free respite or social care, the rapid response to their needs and quick access to community care services, and the additional support after their hospital stay. RRS patients were dissatisfied with inappropriate medical care, insufficient care at their own home, and the short duration of the care.

9.8.2 Limitations and recommendations

Although this study has generated substantial evaluative findings, inevitably it has limitations. Some arise from the failure to achieve an *exact* match between the 'experimental' and 'comparison' groups. Matched sampling is most easily performed when patients are admitted to a trial in sequence, but it is not usually realistic to match on more than three variables (Sim and Wright, 2000). This study planned to match RRS and hospital patients by age, sex and the main clinical problem. It was found that to match by the main clinical problem of the RRS patient sample was not feasible. There were too few eligible patients in the hospital, because the RRS patients were more likely to have high care needs and chronic rather than acute problems. This was especially the case in the first year when the service was at an early stage of development. On the other hand, hospital patients were obviously more likely to have acute illness and associated treatment needs.

The method was pragmatic in that all RRS patients who gave consent to participate between April 2001 and May 2002 were recruited (except for patients who were mentally disabled or who refused to participate). The inclusion criteria for the comparison or control group patients were that they met the RRS service eligibility criteria. The required numbers by sex and age were determined and then to be recruited from the hospital. It proved however too time consuming to match both groups of patients by exact single years of age. The researcher regularly checked (with *t*-tests for mean age and chi-squared tests for sex and age groups) the differences between two groups. No differences in the age group distributions occurred, but a difference of means of 2.9 years (95% CI=0.7 – 3.9) arose between the two groups. It was then found that the control group (hospital patients) presented a different pattern of main medical problems to the RRS patient sample.

This outcome clearly indicates that the RRS patients were more likely to have the care needs associated with chronic disability which are met by quick assessment and access to care by a multidisciplinary team, while the hospital patients were more likely to have acute care needs. An exact match of RRS and hospital patients could therefore never be achieved.

This methodological difficulty clearly compromises the ability of the research to answer the fundamental research (and practice development) question: is the RRS an alternative to hospital care? This question is of vital interest to both service providers and policy makers. This study has however assembled considerable evidence that the RRS is providing a range of services that are not available in the hospital. The RRS to a large extent supplements and complements hospital care, and is only in part an alternative. The RRS is not exclusively a hospital avoidance service.

Further study is therefore required to explore more comprehensively the impact of the RRS on older service users, rather than concentrating on whether the RRS can be an alternative to hospital care. For example, it will be valuable to explore the distinctive impact of the assessment and intervention by the multidisciplinary RRS team, as differentiated from existing community health and social care. Which groups of older people derive most benefit from this service? Another limitation of the study has been the relatively small sample sizes given the heterogeneity of the patient populations and the need to describe several sub-groups by 'place of care' or 'referral pathway'. This has produced wide 95% confidence intervals around the odds ratios for some predictor variables.

Finally, another limitation to the study was exposed during the analysis and interpretation: this is the lack of differentiation between 'dissatisfaction' and 'low expectation' in the satisfaction survey. As previous studies have indicated, patients are more likely to be dissatisfied with aspects of their care which are not a priority to them but are more likely to be satisfied with their care if the service corresponded to their needs (Green and Schoenherr, 1981; Lochman, 1983; Like and Zyzanski, 1987; Korsch, Gozzi, and Francis, 1968). The participants in this study seemed to express dissatisfaction with some features of care when they had very low expectations. It is therefore necessary to be cautious when interpreting the findings. A further study is recommended to discriminate 'dissatisfaction' with a service from low expectations.

Chapter 10

Staff evaluation study

Over the last few years, various kinds of innovative care schemes have been established throughout the UK to meet the older population's needs and to deliver care more efficiently. These care services are intended for older people who need help during the transition between medical treatment and personal independence, but who do not need the specialist medical facilities or interventions of an acute hospital (Vaughan, 1998). Innovative approaches, differentiated from both existing acute hospital care and community health and social care, were therefore required. The new working approaches require collaborative work, not only new multidisciplinary care teams, but also with other care professionals in Community Health Trusts and other agencies.

As revealed by the experience of the RRS in the first year (Chapter 8), although the new way of working and sharing brings many advantages to the patients, professional carers had never previously worked in this way and were unfamiliar with its requirements. There were both teething and recurrent problems in the implementation of the service. To appraise the problems during the implementation of the innovative care service, a survey of the RRS staff was carried out. The main aim was to establish and analyse the problems they experienced of working each other in the multidisciplinary RRS team and with other care professionals. The survey was a systematic survey of the staff's opinions of the strengths, weaknesses and optimal development of the RRS.

This chapter begins by restating the primary research questions. Methodological issues will then be discussed and the study design outlined. The strategies for the data collection and analysis are described, and finally the results are presented and discussed.

Research questions

a) What problems did the RRS team and other collaborative professionals experience with working in an innovative care service?
b) Did members of the RRS team and other collaborative professionals have different views on the achievement of the RRS?
c) Did different care professionals have different opinions about the strengths and weaknesses of the RRS?

d) Did the various care professionals have different opinions about the best way to develop the RRS?

10.1 Study design

10.1.1 Participants

The potential participants for the survey were all RRS multidisciplinary team members and three groups of local care professionals: those who were involved in referring patients to the RRS, those who cared for RRS patients in the resource centres operated by Social Services or in nursing and residential care homes (NRCH), and all those were involved in follow-up care from March 2001 to February 2002. It is estimated that the total number of potential participants over the first year was about 250. In the event, 120 care professionals participated in this study. Among them, 15 were RRS team members (including 3 team leaders, 4 staff nurses, 4 care assistants, 1 physiotherapist, 1 occupational therapist, 1 social worker and 1 coordinator), 27 cared for RRS patients in the resource centres or NRCH, and the remaining 78 were GPs (39), social workers (27), district nurses (2), and hospital staff in A&E and admission wards at the BDGH (10) who referred patients to the RRS scheme or were involved in RRS follow-up care.

10.1.2 Research design and methods

Mixed quantitative and qualitative methods were chosen for the survey. As mentioned in Chapter 9, the following design decisions were required: what variables to examine, how to operationalise the variables, at what times and intervals to collect the data and what methods to employ for data collection (Sim and Wright, 2000). It was decided to use a semi-structured questionnaire, to gather both standardized information and to give the respondents opportunities to describe their individual reactions and views. Most of the questions were pre-coded and closed.

There has recently been an increasing use of focus groups in health care research. The method gathers data through a group interview that is centred on a specific topic and facilitated by a moderator. Focus groups capitalise on the interaction that takes place in the group setting and that tends to produce consensual opinions. This survey method is relatively cheap and convenient for a single researcher, and was adopted due to the limitations of resources and time. It was administered through a postal survey.

10.1.3 Design of instrument

Three variants of the staff questionnaire were designed: one for the RRS team, one for the GPs, and the third for all other staff, *i.e.* those in the resource centres, NRCH, primary health care, social care and the BDGH. The questionnaires included both common questions to compare the views of the different staff, and some that were specific to the particular professions (see Appendix 6).

To assess the dissemination of information about the RRS in the first year, all care professionals (except the RRS team) were asked how and when they became aware of the service. There were also questions about whether the planned aims of the RRS had been achieved. In addition, all staff were asked their views about the government's care policies for older people, and specifically whether the RRS was well designed to meet the needs of older people, and whether they had had difficulties with caring and referrals as a result of rapid changes in the care services. All staff were also asked whether the RRS was a practical alternative to the acute hospital for older people with acute illness and whether they found that some patients with many social problems or chronic medical problems were referred to the RRS as a substitute social service. All the mentioned questions were pre-coded. Moreover, there were three questions about the health problems of older people to which RRS could appropriately respond, and respondents were asked to name three positive features and three problems. An open-ended question sought the respondents' views about alternative service developments for older people.

The RRS team and all other care professionals except GPs were asked about whether RRS patients were more likely to receive community health and social care through its multidisciplinary assessment than hospital patients. In addition, the RRS team members were asked about whether they had met problems in the newly developed service (given the differences from the hospital and existing community care service), and whether they had had problems in working with each other as a multidisciplinary care team and with other care professionals.

The GPs who were involved in referring patients to the RRS and in providing the medical care of the RRS patients were asked about the criteria they applied when referring patients to the RRS. This was to discover whether they knew and used the agreed eligibility criteria. Questions were also asked about whether some patients or relatives of older people were likely to use RRS as respite care, whether the RRS patients increase their work load, and whether they were worried about taking the medical responsibility.

A participant information letter was attached to the front of all the questionnaires (see Appendix 7). This explained the purpose of the study and the confidentiality and data protection procedures that were to be followed.

10.1.4 Procedure of data collection and implementation

Data collection was divided into two phases. At phase 1, a list of the care professionals involved in the RRS care was compiled by face-to-face, telephone and letter inquiries. At phase 2, 15 RRS team members, 97 GPs in the Barnsley Primary Care Trust, 36 social workers attached to the care of older people in Barnsley Metropolitan Borough Council, and 52 hospital nurses and doctors in the A&E and admission wards at the BDGH who became involved in the RRS care (in the first year) were sent questionnaires. Later, 9 district nurses and 42 staff in resource centres and NRCH were sent questionnaires.

One of the main difficulties was a low response rate. The majority of the hospital staff and social workers were asked face-to-face to participate and to complete the questionnaires. Most gave assurances that they would complete and return the questionnaire, but in the event the majority did not return them. Compared to the response rate of the hospital staff and social workers, the RRS team members and the staff in resource centres and NRCH had high response rates. The RRS team achieved 100%, and the staff in resource centres and NRCH 64%.

Morris *et al.* (2001) conducted a postal survey of 759 GPs with a short questionnaire in eight English health authorities and achieved a 55 % response rate. They found that the response rate from London GPs was significantly lower than from elsewhere, and that the questionnaire length and the originating institution were the two major factors influencing their decision to return the survey. Although the GPs' response rate for this study was slightly lower (40%), it was believed reasonable given the length of questionnaire and the inclusion of both closed and open-ended questions.

Of 36 questionnaires sent to social workers in the post, only seven were completed and returned. To increase the response rate, a social worker who had shown interest in the evaluation study agreed (for payment) to distribute the questionnaires to the social workers and encourage their responses. This resulted in 75% of the social workers completing and returning the questionnaires.

The response rate by the hospital staff in A&E and admission ward (the second most frequent RRS patients' referrers) was initially also extremely low (8%). To increase the response rate, the Director of Elderly Care Services agreed to contact the

Director and Managers of the A&E department and the admission ward, and he encouraged the staff to participate. After the second distribution, the response rate (19%) was slightly increased.

10.1.5 Ethical issues

The principal ethical consideration in this element of the research was to maintain the confidentiality of the respondents' answers and opinions. An anonymous identify number was allocated to each person and their names were not entered into the research database. As undertaken in other studies described in the previous chapters, the requirements of the national data protection legislation and the research conduct policies of the University of Sheffield were upheld, and due regard given to the legal and ethical requirements to maintain data safety and confidentiality.

10.2 Strategies for data analysis

This section first describes the methods of data analysis. The aims of data analysis were to provide the answers to the five study questions mentioned earlier. The rationale for using particular statistical tests will be explained together with a brief description of each test.

10.2.1 Statistical analyses

The responses were initially reviewed at the univariate level before progressing to purposeful bivariate analyses. The frequency distributions and content of each variable was carefully examined to gain insight into the range of responses and to identify miscoded or missing data. Bivariate relationships between categorical variables were established using chi-squared statistics, non-parametric testes or 'Exact' statistics[1] (Peat *et al.*, 2002). If the categorical data were non-ordered and each cell had sufficient numbers, Pearson's or continuity-corrected chi-squared tests were used. If the categorical data were non-ordered but each cell had small numbers, 'Exact' methods were used. If the categorical data were ordered, non-parametric statistics were used. These were no continuous or interval variables in this study. So the commonly used

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[1] The difference of 'Exact' methods from the normal is not to rely on any assumptions about sample size or distribution. On the other hand, 'parametric standard' methods are based on assumptions that the sample size is large, the data are normally distributed and the condition of interest occurs reasonably frequently (more than 5 per cent of the population or study sample). If these assumptions are not met, estimates of statistical significance may be inaccurate (Peat, 2002).

(product moment) correlation coefficients were not applicable. Moreover, no multivariate statistical tests were used.

10.2.2 Text-based data analysis

Text-based qualitative data (*i.e.* the staff's statements) were collected with semi-structured and open-ended questions from all care professionals who were involved in RRS care. These were used particularly to collect statements about the health problems of older people to which RRS can appropriately respond, about positive features of the RRS, and about problems of the RRS and alternative service developments for older people. Responses from the semi-structured and open-ended questions were grouped by theme to develop appropriate coding frames (Bowling, 2002). Coding was then undertaken. The most common responses under the variable name were identified and allocated code values (Pallant, 2001). SPSS was then used for statistical analysis.

10.3 Main results

The main findings from the questionnaire survey will now be outlined. 120 care professionals participated in this study. Among those, 15 were RRS team members (including 3 team leaders, 4 staff nurses, 4 care assistants, 1 physiotherapist, 1 occupational therapist, 1 social worker and 1 coordinator), 27 cared for RRS patients in the resource centres or in NRCH, and the other 78 were GPs (39), social workers (27), district nurses (2), and hospital staff in A&E and admission wards at the BDGH (10) who referred patients to the RRS and were involved in the follow-up care.

a) What problems did the RRS team and other care professionals experience with working in an innovative care service?

The RRS team members were asked about the problems that they had experienced working in an innovative care service and in an 'alternative' care setting. Other questions were about the quality of older people's lives, the criteria and guidelines for the work, and whether they had encountered named problems 'often', 'sometimes', 'not often', 'seldom', or 'never'. The results are presented in the rank order of a summary index of 'frequency' (Table 10.3.1). The index has been calculated by weighting the percentages answering to the five semantic differentials. The indexes have a range from 10, when every respondent says that they met the problem 'often', to 0, when every respondent reports 'never'.

'Experiencing difficulties' produced the highest Frequency Index (FI) score (5.3) with 60% of the respondents reporting 'sometimes'. Encountering safety problems associated with the different care circumstances from the hospital, and ethical problems related to the best place for care also produced positive scores (FI= 4.6). The question about whether recent changes in care services for older people were to improve the quality of life for older people or for the benefit of the government, and another about professional and legal problems due to the unsettled criteria or guidelines produced negative scores (FI= 3.2-3.5).

Additional questions presented two assertions about the patient eligibility criteria and the RRS guidelines. The respondents were asked to indicate whether they 'strongly agreed', 'agreed', were 'neutral', 'disagreed', or 'strongly disagreed'. The 'index of agreement' results are presented in Table 10.3.2. The 'agree' index has been calculated as before. Although roughly a half (47% and 60%) reported they have been 'very seldom' or 'never' worried about misleading professional conduct and legal problem due to unsettled criteria or guidelines for work, the questions about the patient eligibility criteria and the guidelines produced low agreement Agree Index (AI) =(0.07-0.14).

Nine RRS team members examples in response to the question about whether they had experienced difficulties working in a new service. Two respondents stated that implementing an effective service whilst trying to ensure all staff received adequate training in the short time scales set by the commissioners had been problematic. Although most RRS team members had adequate work experience for other care settings, they needed further training for multi-disciplinary work in the RRS settings (not in a hospital). In fact, two therapists stated that the lack of understanding of the role of occupational therapist and physiotherapist by other RRS team members had increased their difficulties, and that these had been exacerbated by poor communication within the team. Moreover, two respondents indicated that imperfect understanding of the roles and functions of the RRS had increased inappropriate referrals and wasted the time and resources of the RRS team. Commenting on the inappropriate referrals, one team member stated, "At the beginning we were just learning what we had to accept, we were 'put on' by GP's and social services, but once we had the confidence in the job, then we could say 'no' to referrals that were inappropriate". Another team members said the unclear guidelines for the work were a matter of concern.

Table 10.3.1 The RRS team's problems during working in an innovative service

Hypothetical problem: when you take care of patients,	**Yes, Often**	**Yes, sometimes**	**Not Often**	**Very seldom**	**Never**	**Frequency Index**[1]
	Frequencies (percentages)					
Experienced difficulties during working in a new service?	-	9 (60)	4 (27)	1 (7)	1 (7)	5.3
Been worried about the patient's safety due to the different care circumstances from the hospital?	-	7 (47)	4 (27)	4 (27)	-	4.6
Met an ethical problem related to where is the best place to take care of older people?	2 (13)	6 (40)	1 (7)	3 (20)	3 (20)	4.6
Faced an ethical problem as to whether the change in the care services for older people is for the quality of life for older people, or the benefit of he government?	-	6 (40)	2 (13)	2 (13)	5 (33)	3.5
Been worried about your own safety related to misleading professional conduct due to not settled criteria or guideline for your work?	-	4 (27)	4 (27)	4 (27)	3 (20)	3.2
Been worried about legal problems arising from the unsettled criteria or guidelines for your work?	-	2 (13)	4 (27)	4 (27)	5 (33)	2.3

Notes: Sample size is 15. 1. Possible range from 0 (everyone 'never') to 10 (everyone 'yes, often'). Calculated from the given frequencies as (10 * 'very often' + 7 * 'yes, sometimes' + 4 * 'not often' + 1 * 'very seldom' + 0 * 'never') / 15.

10.3.2 The eligibility criteria for the eligible patients and the placement of care

Assertion	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Agree Index[1]
	Frequencies (percentages)					
The eligibility criteria for RRS patients is are sufficiently clear to make me confident in my acceptance decisions	3 (20)	6 (40)	-	4 (27)	2 (13)	0.14
The criteria for the decision to place the RRS patient at home with a carer, resource centre or nursing home are sufficient	-	8 (53)	3 (20)	2 (13)	2 (13)	0.07

Notes: Sample size (RRS team) = 15; 1. Possible range from + 1 (everyone strongly agrees) to – 1 (everyone strongly disagrees). Calculated from the given percentages as (2*strong agreement + agreement – disagreement -2*strong disagreement) / 200.

The RRS team members, GPs, community health and social care staff, and hospital care staff were asked about various implementation problems associated with working with each other. Four problems were specified: lack of publicity about the new service, issues about referrals, working with various other care professionals beyond the RRS team, and the divergence of views on problems to which RRS can appropriately respond.

Lack of publicity about a new service

The RRS was established in December 2000. Among the 51 respondents[2] including GPs, staff in resource centres and NRCH, community health and social care staff and hospital staff, only 37 % (n=19) were aware of the RRS before January 2001; 37 % (n=19) became aware of it between January and June 2001, and 26 % (n=13) after July 2001. There was no statistically significant difference in the levels of awareness of the RRS between GPs and other care professionals (Fisher's exact; χ^2= 0.2; df=1; p=1.0). Of 102 respondents[3], 48% (n=49) became aware of the RRS through a letter or leaflets from the RRS or PCG (Primary Care Group), 6% (n=6) through telephone calls from the RRS, and the other 46% (n=47) through word of mouth and visits by the RRS team and meetings.

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[2] Among 105 total participants excluding the 15 RRS team members, 54 did not respond.

[3] Among 105 total participants excluding the 15 RRS team members, 3 did not respond.

Four RRS team members described their worries about their own safety in connection with misleading professional conduct due to the unclear eligibility criteria or guideline for their work. When making decisions about referrals, some were worried about the fine line between acute and chronic illness. They believed that some RRS-admitted patients were really too ill and needed more specialist care in hospital. Additionally, some team members stated that they were particularly worried when they cared for a patient with burns in a nursing home, where they were unable to provide aseptic wound treatment. A RRS team member gave an example of a legal problem arising from the unclear guidelines. If a patient was be too ill for the RRS care and ended up going to hospital, the family often asked why they had not been directly admitted to hospital.

Issues on referrals

GPs were asked what criteria they applied when referring patients to the RRS. Multiple responses from the list of criteria and other answers were allowed. The results are presented in Table 10.3.3. The two most frequent considerations were medical condition and the patient's or relative's agreement. Patient's age and functional ability, availability of an informal carer during the RRS care scheme, cognitive ability, and the capacity of the RRS were also mentioned frequently. Answers beyond the listed criteria included keeping a patient in the practice locality during the care scheme, and the availability of hospital beds.

Table 10.3.3 RRS patients criteria applied by GPs

Criteria	Frequencies	Percentage
Medical condition	34	16.5
Patient's or relative's agreement	31	15.0
Patient's age	28	13.6
Patient's functional ability	28	13.6
Availability of an informal carer	25	12.1
Cognitive ability	25	12.1
The capacity of the RRS	23	11.2
Others	12	5.9

Notes: Responses were from 40 GPs with a question require multiple responses. Total responses=206; Others (n=12) include remaining patients in practice locality (9), and capacity of hospital service (3).

The GPs were asked about whether a patient or relative who had used the RRS before or who knew about the service had asked them to refer to RRS for respite care. Of 37 GP respondents, 14% (n=5) responded 'yes'. In order to identify the use of RRS for people with social and long-term disabled conditions, the RRS team and other collaborative care professionals including GPs were asked whether they had found that some patients with many social problems or long-term medical problems (not acutely ill enough to admit to hospital) had been referred to RRS as a substitute for social services. The results and a summary index of 'frequency' are presented in Table 10.3.4. The 'frequency index' has been calculated in the same way as described above. The frequency index scores for the different groups of care professionals reveal great differences, especially between the RRS team members (service providers) and the GPs (most frequent referrers). In particular, all the RRS team reported a high frequency of such cases (often or sometimes). This finding suggests that the eligibility criteria for patients were not consistently understood or applied by the different groups of care professionals.

Table 10.3.4 Referrals of patients with social problems or long-term medical problem

Assertion		Very Often	Yes, sometimes	Not often	Very seldom	Never	Frequency Index[1]
		Frequencies (Percentages)					
Have you found that some patients with many social problems or long-term medical problems (not acutely ill enough to admit to hospital) were referred to RRS to use the RRS like social service?	RRS	9 (60)	6 (40)				6.3
	CHSH[2]	9 (14)	37 (57)	13 (20)	6 (9)		6.3
	GPs		13 (34)	9 (24)	10 (26)	6 (16)	3.6

Notes: Sample size is 120 (RRS team = 15, community health and social and hospital care staff = 65, GPs = 38, Missing n = 2); 1. Possible range from 0 (everyone 'never') to 10 (everyone 'very often'). Calculated from the given percentages as (10 * 'very often' + 7 * 'yes, sometimes' + 4 * 'not often' + 1 * 'very seldom' + 0 * never) / 100; 2. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH.

Working with other care professionals

The RRS team members were asked to indicate whether they had experienced problems working with other (non-RRS) care professionals 'often', 'sometimes', 'not often', 'very seldom', or 'never'. The results are presented in Table 10.3.5 in the rank order of the 'frequency index'. 54% had 'often' or 'sometimes' experienced communication problems with other care professionals. The RRS team members presented polarized responses to the questions about the working difficulties with other care professionals.

Among the three groups of care professionals (GPs, hospital staff, social workers), the RRS team members most frequently experienced difficulties with working with hospital staff (FI=4.2). 40% reported that they 'often' or 'sometimes' experienced a problem with GPs when they were asked to take medical responsibility for the RRS patients, and 37% stated that they had 'often' or 'sometimes' experienced difficulties with GPs when they wanted to discuss the RRS patient's changed medical condition or treatment. These rates indicate that a high percentage of the RRS team members experienced difficulties working with GPs.

In contrast, the GPs were questioned about the acceptance of medical responsibility for the RRS patients, their workload, remuneration and problems between GPs and the RRS team. Of 37 GP respondents, 70% (n=26) accepted the medical responsibility for all the RRS patients, but 30% (n=11) accepted only in some cases. Two respondents who answered 'agree in some cases' specified not when patients were placed in a nursing home outside their practice area.

36 GPs answered a question about whether taking medical responsibility for the RRS patients increased their workload (using the semantic differential: *not at all, slightly, moderately, quite a bit* and *extremely)*. Of those, 14% (n=5) and 50% (n=18) responded *not at all* and *slightly* respectively, while 22% (n=8) and 14% (n=5) responded respectively *moderately* and *quite a bit*. In addition, 49% (n=18) agreed with the assertion that taking on the medical responsibility was insufficiently remunerated, 38% (n=14) were *neutral*, and just 14% (n=5) disagreed. Furthermore, 37 GPs answered a question whether the RRS team formed an inappropriate barrier between them and the RRS patients with using a three point Likert scale. Of those, 73% (n=27) disagreed and 19% (n=7) were neutral while 8% (n=3) agreed.

Some respondents who answered '*yes, often*' or '*yes, sometimes*' to the question about whether they have found difficulties working with hospital staff stated that some lacked insight into the role of the RRS. RRS team members also gave examples of the difficulties experienced with working with social workers. They reported that social workers used the RRS for older people with social care needs and that increasing referrals for free home or respite care considerably increased the RRS team's workload in assessing referrals. Difficulties in reaching social workers for follow-up care when discharging RRS patients was also mentioned. It often delayed the discharge of the RRS patient.

Table 10.3.5 Working with other care professionals

Questions	Very often	Yes, sometimes	Not often	Very seldom	Never	Frequency Index[1]
	Frequencies (percentages)					
Have you experienced problems with communication between care professionals?	1 (7)	7 (47)	6 (40)	1 (7)	-	5.6
Have you experienced difficulties with working with staff in the BDGH A&E or admission wards?	1 (7)	5 (33)	3 (20)	6 (40)	-	4.2
Have you experienced problems when you asked GPs to take on the medical responsibility of the RRS patients?	1 (7)	5 (33)	4 (27)	2 (13)	3 (20)	4.2
Have you experienced difficulties working with social workers?	1 (7)	5 (33)	3 (20)	2 (13)	4 (27)	3.9
Have you experienced difficulties with GPs when you wanted to discuss a RRS patient's changed medical condition or treatment?	1 (7)	3 (20)	4 (27)	3 (20)	4 (27)	3.3

Notes: Sample size is 15; 1. Possible range from 0 (everyone 'never') to 10 (everyone 'very often'). Calculated from the given frequencies as (10 * 'very often' + 7 * 'yes, sometimes' + 4 * 'not often' + 1 * 'very seldom' + 0 * 'never') / 15.

Different views on problems to which RRS can appropriately respond

120 care professionals including the RRS team and other involved care professionals were asked to specify up to three problems of older people to which RRS can appropriately respond. The aim was to identify whether there were differences of view about patient eligibility criteria between the RRS and other care staff. The results are presented in Table 10.3.6 in the rank order of the frequencies. The three most frequently cited problems were chest infection or COPD, falls, and deterioration (physically and medically). Nevertheless, the three most frequent responses by the three

different groups of professionals (RRS team, GPs and others) were remarkably different (except that 10% of all groups mentioned 'deterioration').

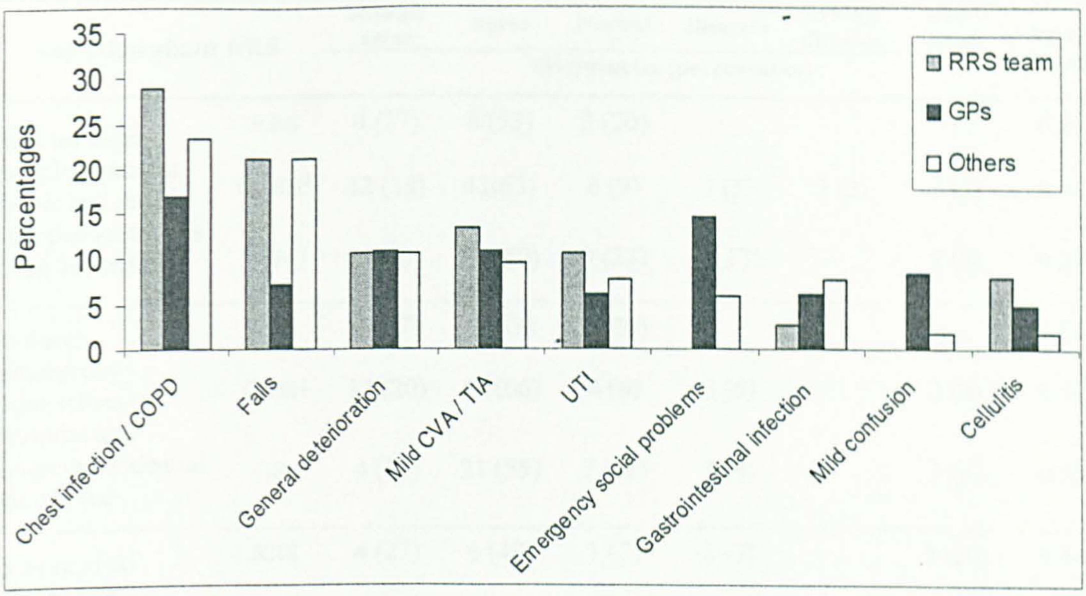
The frequency of references to the nine most commonly cited problems by the different three groups of care staff are compared in Figure 10.3.1. Not one member of the RRS team mentioned an emergency social problem, but it was the second most frequently cited problem by GPs. Mild confusion or early dementia was not cited at all by the RRS team, but it was the fifth most frequently mentioned problem by GPs. The wide range of views about the problems to which RRS can appropriately respond must have been a major factor in the conflicts around referrals.

Table 10.3.6 The views about the problems to which RRS can appropriately respond

Problems	Care professionals			Total
	RRS team	GPs	Others[1]	
	Frequencies (percentages)			
Chest infection or COPD	11 (28.9)	14 (16.9)	40 (23.4)	65 (22.3)
Falls	8 (21.1)	6 (7.2)	36 (21.1)	50 (17.1)
Reduced mobility or medically deteriorated	4 (10.5)	9 (10.8)	18 (10.5)	31 (10.6)
Mild CVA or TIA[2]	5 (13.2)	9 (10.8)	16 (9.4)	30 (10.3)
Urinary tract infection	4 (10.5)	5 (6.0)	13 (7.6)	22 (7.6)
Emergency social problems		12 (14.5)	10 (5.8)	22 (7.6)
Gastrointestinal infection	1 (2.6)	5 (6.0)	13 (7.6)	19 (6.5)
Mild confusion or early dementia		7 (8.4)	3 (1.8)	10 (3.4)
Cellulitis	3 (7.9)	4 (4.8)	3 (1.8)	10 (3.4)
Generally unwell after recent discharge from hospital		4 (4.8)	2 (1.2)	6 (2.1)
Diabetes	1 (2.6)	2 (2.4)	3 (1.8)	6 (2.1)
Cardiac failure		1 (1.2)	5 (2.9)	6 (2.1)
Others[3]	1 (2.6)	5 (6.0)	9 (5.3)	15 (4.9)
Total	38	83	171	292 (100.0)

Notes: 1. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH; 2. TIA (Transient ischaemic attacks); 3. Includes gout (1), MRSA (Methicillin Resistant Staphylococcus Aureus: 1), shingles (1), ischaemic heart disease (1), nutrition problem (1), incontinence (1), nursing supervision for acute illness (1), blood pressure monitoring (2), terminal illness (3), reviewing of medication needs (3).

Figure 10.3.1 Views on problems to which RRS can appropriately respond



b) Did member of the RRS team and other care professionals have different views on the achievement of the RRS?

The RRS team and all other care professionals involved in the RRS were asked the same questions about the views on the achievement of the service aims and the purpose of the service. The questions were in the form of assertions and the respondents were asked whether they 'strongly agreed', 'agreed', were 'neutral', 'disagreed', or 'strongly disagreed'. They could also answer 'don't know'. The results presented in Table 10.3.7, 10.3.8 and 10.3.9 include a summary 'agree index'. The index has been calculated by weighting the percentages answering to the four semantic differentials. The indexes range from +1, when every respondent 'strongly agreed' with the assertion, to -1, when every respondent 'strongly disagreed'.

The respondents views about the achievement of the RRS are presented in Table 10.3.7. On balance, the respondents agreed that the three aims were attained. The average index of all care professionals were +0.42 for the first assertion, +0.47 for the second and +0.37 for the third. Among all three groups of professionals (the RRS team, GPs and other care professionals), most agreed with the second assertion that the RRS reduces emergency admissions to hospital and nursing and residential care-homes, and fewest agreed with the third assertion, that RRS is a practical alternative to acute hospital services. Among the three different care professionals, GPs least agreed with all three assertions, and the RRS team most agreed. The RRS team members had the least variation in their views.

Table 10.3.7 Opinions about the achievement of the RRS aims

Assertion about RRS		Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know	Agree Index^1
		Frequencies (percentages)						
Enables older people to stay at home and remain independent for as long as possible	RRS	4 (27)	8 (53)	3 (20)				0.54
	CHSH^2	12 (18)	41(63)	6 (9)	3 (5)	2 (3)	1 (2)	0.44
	GPs	3 (8)	19 (50)	9 (24)	5 (13)		2 (5)	0.27
Reduces emergency admissions to hospital and nursing residential care home	RRS	4 (27)	8 (53)	3 (20)				0.54
	CHSH	13 (20)	43 (66)	4 (6)	3 (5)		2 (3)	0.51
	GPs	4 (11)	21 (55)	7 (18)	3 (8)		3 (8)	0.35
Is a practical alternative to acute hospital service for older people with acute illness	RRS	4 (27)	6 (40)	1 (7)	1 (7)		3 (20)	0.44
	CHSH	9 (14)	40 (62)	6 (9)	4 (6)	4 (6)	2 (3)	0.36
	GPs	4 (11)	23 (61)	2 (5)	6 (16)	1 (3)	2 (5)	0.31

Notes: Sample size is 120 (RRS team = 15, community health and social and hospital care staff = 65, GPs = 38, Missing n = 2); 1. Possible range from + 1 (everyone 'strongly agrees') to – 1 (everyone 'strongly disagrees'). Calculated from the given percentages as (2 * 'strong agreement' + 'agreement – disagreement -2*strong disagreement) / 200; 2. CHSH (community health and social care and hospital care staff) includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH.

The respondents were asked about the purpose of the RRS service and the results are displayed in Table 10.3.8. All three groups similarly disagreed with the assertion that RRS primarily served the political purpose of the current government and was not dedicated to the needs of older people. Among the three groups of respondents, the RRS team disagreed most with the assertion, and GPs disagreed least. Similar to the results presented in the Table 10.3.7, the RRS team members were more unanimous in their disagreement, but the GPs and other care professionals presented disparate views.

Table 10.3.8 The views on the purpose of RRS service

Assertion		Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know	Agree Index[1]
		Frequencies (percentages)						
RRS is just a 'new idea' that serves the political purposes of the current government and it is not well designed to meet the needs of older people	RRS			3 (20)	6 (40)	5 (33)	1 (7)	-0.53
	CHSH[2]	3 (5)	2 (3)	8 (12)	44 (68)	6 (9)	2 (3)	-0.37
	GPs	3 (8)	3 (8)	7 (18)	16 (42)	5 (13)	4 (11)	-0.22

Notes: Sample size is 120 (RRS team = 15, community health and social and hospital care staff = 65, GPs = 38, Missing n = 2); 1. Possible range from + 1 (everyone 'strongly agrees') to – 1 (everyone 'strongly disagrees'). Calculated from the given percentages as (2 * 'strong agreement' + 'agreement' – 'disagreement' -2 * 'strong disagreement') / 200; 2. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH.

All three groups of respondents were asked about the achievement of the multi-disciplinary team assessment, but note that the question about follow-up care was put only to the RRS team and other care professionals (not GPs). The results are presented in Table 10.3.9. All groups on balance agreed that the RRS enables a more comprehensive assessment of risk and the social and health care needs of older people than hospital care, although the level of 'agreement' differed. Among the three groups of respondents, the RRS team members agreed most with the assertion and GPs agreed least. Nonetheless, 74% of GPs notably agreed that RRS offers more comprehensive assessment than hospital care. The RRS team and community health, social and hospital scare staff were less in agreement with assertions about follow-up care.

Table 10.3.9 Achievement of multi-disciplinary team assessment and on-going follow-up care

Assertion		Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Don't know	Agree Index[1]
		Frequencies (percentages)						
RRS enables a more comprehensive assessment of risk and the social and health care needs of older people than hospital care*	RRS	4 (27)	9 (60)	2 (13)				0.57
	CHSH[2]	10 (15)	38 (59)	10 (15)	4 (6)		3 (5)	0.42
	GPs	3 (8)	25 (66)	2 (5)	5 (13)	1 (3)	2 (5)	0.32
RRS patients are more likely than hospital patients to receive social services after discharge**	RRS	2 (13)	7 (47)	3 (20)	2 (13)		1 (7)	0.30
	CHSH	7 (11)	27 (42)	12 (18)	10 (15)		9(14)	0.25
RRS patients are more likely than hospital patients to receive community health services after discharge**	RRS	3 (20)	5 (33)	5 (33)	1 (7)		1 (7)	0.33
	CHSH	10 (15)	31 (48)	7 (11)	5 (8)		12 (18)	0.35

Notes: * Sample size is 120 (RRS team = 15, community health and social and hospital care staff = 65, GPs = 38, Missing n = 2);** Sample size is 80 (RRS team=15; community health and social and hospital care staff =65; GPs were excluded) 1. Possible range from + 1 (everyone strongly agrees) to – 1 (everyone strongly disagrees). Calculated from the given percentages as (2*strong agreement + agreement – disagreement -2*strong disagreement) / 200; 2. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH.

c) Did different care professionals have different opinions about the strengths and weaknesses of the RRS?

Strengths of the RRS

120 care staff including the RRS team, and the associated care professionals were asked to list up three positive features of the RRS. The results are presented in Table 10.3.10 in the rank order of the frequencies. The three most frequent responses were: to prevent hospital admissions; to respond rapidly to the patient's needs (as for nursing care; occupational therapy, physiotherapy, social care, free placement, and prosthetic equipment); and to enable people to stay in own home. Assessment, intervention and correct discharge care by the multi-disciplinary team were also mentioned relatively frequently as positive features by all care staff.

On the other hand, three features were often mentioned by the GPs and other care staff but not by the RRS team: improved liaison between the health and social services through joint working, rapid rehabilitation, and the involvement of informal caregivers in care. In addition, some GPs gave positive reports of specific aspects of nursing (*e.g.* care supervision, monitoring conditions and ensuring medication). Some social workers said that positive features of the RRS were that it helped to avoid premature entry to a care home, and took work from other over-stretched professionals. These benefits were not reported by any other group of care staff.

Among the respondents said that RRS enabled a rapid response to nursing care needs, some GPs added that RRS referrals were quicker and easier than hospital admissions. Among the respondents who said that RRS enabled people to stay in their own homes, some added that the RRS patients were less likely than hospital patients to lose confidence in their own ability and that another advantage was that staying in their own homes meant that the RRS patients avoided further complications due to hospital care (*e.g.* infection).

Table 10.3.10 Positive features of the RRS

Positive features	Responding care professionals			Total
	RRS team	Others[1]	GPs	
	Frequencies (percentages)			
Prevent a hospital admission	8 (19.0)	32 (20.4)	14 (15.6)	54 (18.7)
Quick response to needs for nursing care, OT, PT, social care, free placement, and equipment	7 (16.7)	26 (16.6)	19 (21.1)	52 (18.0)
Enable people to stay in the familiar and supportive surroundings of their own home	11 (26.2)	24 (15.3)	15 (16.7)	50 (17.3)
Assessment, care, treatment and appropriate follow-up discharge care by a multi-disciplinary team	6 (14.3)	30 (19.1)	12 (13.3)	48 (16.6)
Flexible patient arrangements in community through joint working with social services and the private sector	5 (11.9)	14 (8.9)	13 (14.4)	32 (11.1)
24-hour service for 7 days	3 (7.1)	9 (5.7)	2 (2.2)	14 (4.8)
Response to emergency social problem for a patient or their relatives	1 (2.4)	5 (3.2)	3 (3.3)	9 (3.1)
Increased liaison between health and social services through joint working		8 (5.1)	1 (1.1)	9 (3.1)
Supervision and monitoring			7 (7.8)	7 (2.4)
Rapid rehabilitation		3 (1.9)	1 (1.1)	4 (1.4)
Others[2]	1 (2.4)	6 (3.8)	3 (3.3)	10 (3.5)
Total	42 (100)	157 (100)	90 (100)	289 (100)

Notes: Respondents were asked to list up three positive features of the RRS. 1. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH. 2. Includes involvement of informal caregivers in care, the avoidance of premature entry to a care home, taking work from overstretched professionals, administering medication via intravenous injection at home, clear care pathways and £100 reimbursement for medical responsibility.

Weaknesses of the RRS

The respondents were asked to list up to three negative features of the RRS. The results are presented in Table 10.3.11 in the rank order of the frequencies, and the various responses of the three groups of care staff are presented in Figure 10.3.2. Considerable differences in the views of the different groups of staff are shown. The three most frequent responses were: inappropriate use of residential or nursing homes, the abuse by some families and disciplines of the RRS as a short cut to 'free care', and inappropriate criteria by which to distinguish medical and social needs.

The most frequently mentioned negative feature of the RRS was the reluctance to select NRCH as the placement for care. It was most commonly stated by GPs and social workers. They thought that the tendency to keep RRS patients at home was because the service lacked the capacity to cover a large area for 24 hours and on 365 days a year. The RRS team members did not however consider the patients' placements inappropriate.

The second most frequently reported negative feature of the RRS was the abuse of the service as a short cut to 'free care'. It was most commonly reported by the RRS team and social workers: few GPs gave this response. The supplementary statements differed. Social workers found difficulties with providing follow-up care because the RRS generated high expectations among the patients and their relatives, and some discharged RRS patients became highly dependent on large and expensive 'care packages'. Furthermore, some of the RRS patients did not want to leave the care home in which they had been placed but neither did they want to pay for continuing social services. Some social workers therefore said that the RRS team should take into account relatives' (or friends') ability to support the older patients.

The third most frequently responded negative feature of the RRS was the inappropriate patient criteria. It was reported by all the staff groups, although their views on the patient eligibility criteria were markedly different. The RRS team reported that other care professionals tried to use the RRS to access social services, especially for patients with social, mental and long-term medical problems. In particular, some of the RRS team stated that staff in A&E referred 'anyone' who 'wasted their time on pointless assessments'. GPs reported that the eligibility criteria were too narrow, and that they made it impossible to provide intermediate care services. They added while that the RRS should not be a substitute for *acute* hospital care, the RRS team often refused to take the patients whose condition was close to but not in their judgement acute. Social workers also reported that the RRS was inappropriate for patients with a persistent acute medical problem.

The fourth most frequently responded negative feature of the RRS was that it took a long time for the innovative multi-disciplinary working to become effective. This was reported by the RRS team and all other care professionals except GPs. The RRS team added descriptions of the difficulties they had had with specific disciplines. They also mentioned the inconsistent admissions and the insecurity of the night staff during the first year of the service. Before a social worker joined the RRS team, the compulsory assessment by a social worker for the discharged patient had often been delayed and it blocked the RRS's ability to admit other patients.

The fifth frequently responded negative feature of the RRS was the additional pressure on GPs, which not surprisingly was mostly reported by GPs. Their supplementary statements explained that the pressure to use RRS was because of the shortage of the hospital beds. One result was that A&E referred many to the RRS without consultation. The GPs assumed that the A&E doctors did this because of the shortage of beds, and stated that this increased the GP's workload without increased remuneration. On the other hand, some GPs emphasised that their difficulties were not financial but that they had no time for the increased work. The GPs difficulties were reflected in the concerns experienced by some relatives of the RRS patients, for they thought that they 'would be better off in hospital'.

Two features of the RRS had equal sixth rank in reported frequency. One was the limited duration of care and the use of RRS as a short-term solution. This was reported only by the associated care professionals, not the RRS team. Some respondents added that the fixed length of the care regardless of the stage of the patient's recovery was unrealistic and did not meet the needs of the older people. The other was that RRS made misleading medical assessments. It was mainly a concern of the GPs, but also of some hospital staff and social workers. GPs also said that it was hard to do diagnostic tests and rapid investigations in the RRS care settings (*i.e.* outside the hospital), which contributed to missed or wrong diagnoses and to neglected risks.

Some of the collaborating care professionals added comments about communication problems. According to the staff of NRCH or the resource centres, they had to admit RRS patients at too short notice and with insufficient patient information. They did not therefore have enough time to assess the patients before they were admitted. They also mentioned that they often had little information about the transport arrangements and follow-up care for discharged patients. On the other hand, social workers complained that the RRS team sent unqualified support workers to the multi-disciplinary team meetings to arrange discharge and follow-up social care.

Some other care professionals (non-RRS team) reported that a negative feature of the RRS was that it devalued existing care services. They also said that the administration costs of the scheme meant less funds going direct to other care services, and that RRS had decreased the quality of community care and led to the removal of care professionals from the community care services. Some suggested that the RRS wasted scarce resources, or, more specifically, decreasing the resources for the local authority community care team that had been an effective interface between the NHS and social services.

Some GPs and staff in the care home or resource centre said that some RRS patients were overwhelmed by the visits and questions of various staff during the short care episode, and furthermore stated that some patients complained about being asked too many similar questions. The staff in care home mentioned that too many RRS team members visited the RRS patients within a couple of days of the admission, and that these often disrupted the care of their other residents.

Figures 10.3.2 Views on the problems of the RRS by various care professionals

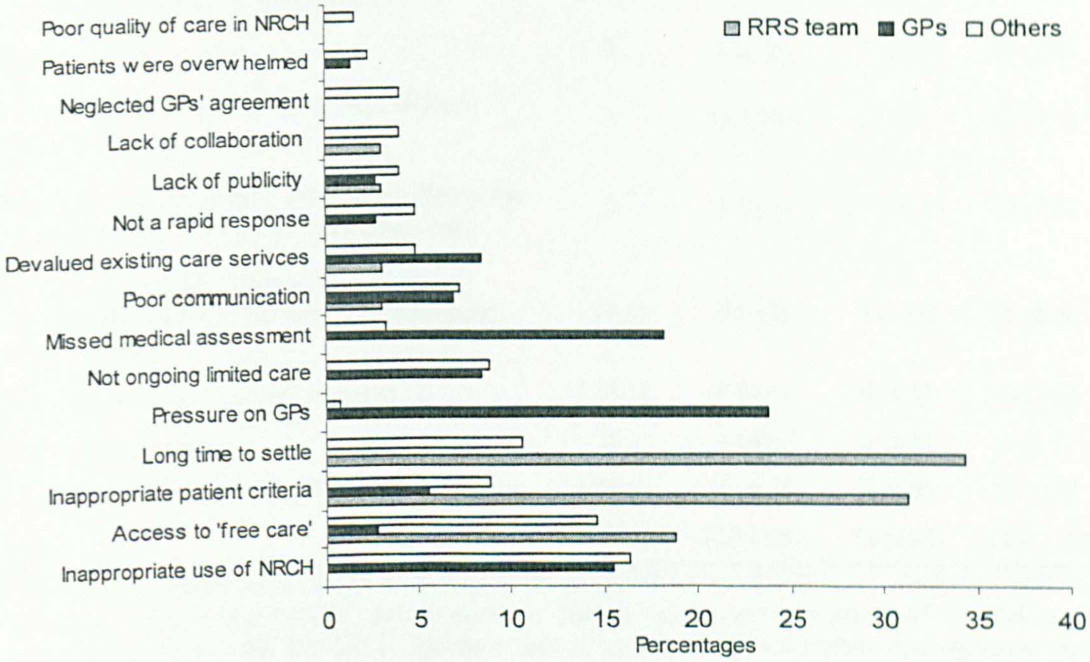


Table 10.3.11 Views on the problems of the RRS by various care professionals

Problems	Responding care professionals			Total
	RRS team	Others[1]	GPs	
	Frequencies (percentages)			
Reluctance to place patients in residential or nursing homes for the RRS care	0	20 (16.3)	11 (15.5)	31 (13.7)
Abuse by some relatives and disciplines as a short cut to 'free home care and NRCH'	6 (18.8)	18 (14.6)	2 (2.8)	26 (11.5)
Inadequate criteria to distinguish between medical and social needs	10 (31.3)	11 (8.9)	4 (5.6)	25 (11.1)
Time taken for the innovative service and multi-disciplinary to settle down	11 (34.4)	13 (10.6)	0	24 (10.6)
GPs' pressure of work	0	1 (0.8)	17 (23.9)	18 (8.0)
The limited duration of care is only a short-term solution	0	11 (8.9)	6 (8.5)	17 (7.5)
Missed or wrong medical assessment due to the difficulty of carrying out diagnostic tests	0	4 (3.3)	13 (18.3)	17 (7.5)
Poor communication among RRS team members and between them and other care professionals	1 (3.1)	9 (7.3)	5 (7.0)	15 (6.6)
RRS devalues existing care services	1 (3.1)	6 (4.9)	6 (8.5)	13 (5.8)
Not a rapid response	0	6 (4.9)	2 (2.8)	8 (3.5)
Lack of publicity about the RRS	1 (3.1)	5 (4.1)	2 (2.8)	8 (3.5)
Total	32 (100)	123 (100)	71 (100)	226 (100)

Notes: Respondents were asked to list up to three problems of the RRS. 1. Includes staff in resource centres and NRCH, social workers, district nurses and hospital staff in A&E and admission ward at the BDGH. 2. Includes lack of collaboration with other care agencies, the neglect of GPs' agreement about medical responsibility, patients overwhelmed by the visits and question of various disciplines in the short-term, poor quality of care in NRCH, increasing stress for family carers, lack of facilities to help rehabilitation, the shortage of resources, and inconsistent availability of intravenous medication.

d) Did the different care professionals have different opinions about the best way to develop the RRS?

The last question in the questionnaire was open-ended and asked about comparable or alternative service developments. It generated few responses. Only 6 RRS team members, 12 GPs and 11 other care professionals responded. Most of their comments about alternative service development stressed the current problems of the RRS and were in effect recommendations to solve those problems.

Some RRS team members recommended that RRS work more closely with other intermediate care and out-of-hours services, as through one referral point. The main reason was because some patients who were not accepted for RRS care were repeatedly referred by different care services. This led to delays in the admission process and increased the stress on the older people concerned. Additionally, some RRS patients had to move from service to service because they had not fully recovered when the RRS episode expired. This also increased the stress on the older people, and required other care professionals to undertake time consuming assessments. Many staff recommended the integration of the rapid response service with the hospital-at-home and with rehabilitation and recuperation in resource centres.

A stronger partnership with A&E and the hospital admission wards and the involvement of geriatric consultant was recommended by RRS team members to alleviate the problems with diagnostic tests, the inadequate medical supervision and interventions by the patients' own GPs, and blocked hospital admissions. On the other hand, some care professionals believed that the RRS service devalued the existing hospital and community health and social care services, and others said that it duplicated care. Many of these advocated the use of acute hospital admissions together with the very rapid arrangement of social service care packages by a multidisciplinary team in the hospital. They considered that this procedure would be much safer and a practical alternative to the RRS. Some GPs and social workers believed that the RRS was incapable of caring for older people with acute medical problems, but capable of caring for older people with emergency social care needs. They keenly recommended a fuller and clearer set of patient eligibility criteria for the service.

10.4 Discussion of findings

a) The problems experienced by the RRS team and other care professionals in an innovative care service

The RRS team members experienced various problems with working in an innovative care service, partly because of the different care circumstances to the hospital, uncertainty about the best place to care for older people, and the imprecise eligibility criteria and guidelines for the work. Moreover, the opinion survey has identified numerous problems of the close working between the RRS team and associated care professionals. The problems were categorised into four themes (lack of publicity about a new service, issues on referrals, working with various other care professionals beyond the RRS team, and different interpretations of the problems to which RRS can appropriately respond) (Table 10.3.1).

Lack of publicity about a new service

Among the RRS-associated care professionals, only 37% had become aware of the RRS within one month of its establishment. That percentage increased to 74 within seven months of its establishment. Several of the opinions about the weaknesses of the RRS can be partly explained by the lack of publicity about the new service and the resulting poor understanding. Many GPs and social workers said that they did not have 'proper' information about the services and called the RRS a 'word of mouth' scheme. Some social workers added that the local GPs seemed unaware that they could refer to the RRS and that it often took a long time to refer to the scheme. These findings suggest that it takes a considerable time to inform care professionals about the role and operation of a new service, and that poor-information dissemination hinders the operation of a service.

Issues on referrals

GPs similarly considered many criteria in their referrals: medical conditions of the patient, patient's (or family) agreement, patient's age, patient's functional ability, the availability of an informal carer, cognitive ability, and the capacity of the RRS (Table 10.3.3). Among these criteria, patient's age, functional ability, availability of an informal carer, cognitive ability, and the capacity of the RRS would not be as relevant when referring a patient to the hospital. It suggests that the GPs who were the main referrers to the RRS did not believe that the RRS was a substitute for hospital care.

The problems of producing matched samples of hospital and RRS patients were discussed in Chapter 9. The hypotheses that there is an age difference between RRS and hospital patients (RRS patients are older than hospital patients) and that RRS patients have more severe functional problems than hospital patients were confirmed because the main referrers of the RRS took into account the patients' age and functional ability. In other words, the GPs tended to refer relatively old people with more severe functional problems to the RRS, and relatively young elderly people with fewer functional problems (and maybe acute medical problems) to the hospital. This raises the possibility that one effect of the RRS was that older people had a decreased chance of being appropriately cared for in hospital. In fact, as the professionals' negative comments about the RRS showed, there was a persistent problem with incomplete and wrong medical assessments by the RRS. These problems are a matter of concern and should be addressed.

The results presented in Table 10.3.4 showed very diverse views about the RRS amongst the RRS team, GPs and other care professionals. The RRS team tended to think that many of the referrals were inappropriate, because they were cases of social or long-term medical problems. On the other hand, GPs tended to believe that patients with social or long-term problems were appropriate. The strong opinions of the RRS team members demonstrate a substantial level of dissatisfaction with the referrals. These findings suggest that the providers' and the referrers' understanding of the patient eligibility criteria was far from the same.

Working with other care professionals

The results presented in Table 10.3.5 show that the RRS team members experienced problems in communicating with other care professionals and particularly hospital staff. About two-in-five also experienced problems working with GPs and social workers. On the other hand, 14% of GPs reported that taking responsibility for the RRS patients had increased their workload, and that they were dissatisfied with the remuneration for taking on the medical responsibility. Some GPs were indeed very dissatisfied with the increased workload without compensation, while others were keen to explain that their problem was less financial reimbursement than the time demands.

According to some of the RRS team members who reported difficulties working with other care professionals, the major problem was the increased workload that arose from inappropriate referrals. The team thought that the lack of understanding about the roles of the RRS was the main cause. The findings seem to indicate, however, that disagreements about service aims, purposes, and the eligibility criteria were the main problems rather than a broader lack of understanding.

Views about the problems to which RRS can appropriately respond

There were different views on the problems to which RRS could appropriately respond. In particular, there was almost complete disagreement between the service providers and the referrers about the RRS's suitability for patients with emergency social problems and mental health problems. GPs, who were frequent referrers to the RRS, were most likely to disagree with the views of the RRS team about the problems to which RRS could appropriately respond. In other words, GPs were most likely to think that problems dissociated from acute physical health problems were appropriate for the RRS, while the RRS team were most likely to hold the inverse view. As discussed earlier, these large differences were a leading cause of the difficulties in collaborative working between the RRS team and other care professionals.

b) Care professionals' views on the achievement of the RRS

Opinions about the extent to which the RRS aims were achieved varied among the groups of care professionals. The RRS team members most believed that they had achieved the service aims, while the GPs were most doubtful. It should be remembered that the GPs most disagreed with the RRS service aims, and doubted if they would be achieved. All professional groups firmly believed that being a practical alternative to acute hospital service with for patients an acute event was the aim that was least achieved by the RRS. Almost all RRS team members 'strongly agreed' or 'agreed' with this assertion, and other groups of care staff rather less.

As to other opinions about the achievements of the RRS, the team members most disagreed with the assertion that RRS principally served the political purposes of the current government and was not well designed to meet the needs of older people. The GPs had the least disagreement with these two assertions. Although all the three groups of care staff on balance disagreed, there was a consensus only among the RRS team and the other generated diverse answers. Some 16% of GPs and 8% of community and hospital care staff thought that the RRS was established for political purposes and was not dedicated to the needs of older people. The multi-disciplinary team assessment and the scheme's follow-up care were seen as positive achievements by all groups of care staff. The 'agree score' of the GPs was however the lowest, and that by the RRS team the highest.

c) Opinions about the strengths and weaknesses of the RRS

Strengths of the RRS

As presented in Table 10.3.10, the three most substantial positive features of the RRS were: hospital admission avoidance, rapid response to the patient's needs through the multi-disciplinary care team's assessment and interventions, (with nursing care, occupational therapy, physiotherapy, social personal care, free residential or nursing care home placement, or aids and equipment service) and the delivery of care in the patients' homes.

Some GPs reported specific aspects of nursing care (supervision and monitoring condition and ensuring) as a positive feature of the RRS. They referred to forms of care that had previously been provided by district nurses. This suggests that some GPs saw the RRS as a replacement district-nursing service. Similarly, some social workers saw the RRS as taking work from other busy professionals, as with its interventions with emergency social problems, and providing older people and their relatives' respite by providing care at a NRCH or the resource centre. These views suggest that they also saw the RRS as providing duplicate or the substitute community health and social care.

Weaknesses of the RRS

As the findings in Table 10.3.11 and Figure 10.3.2 show, there were many negative views about the RRS amongst the different groups of care professionals. The most frequently mentioned, the inappropriateness of placement in NRCH, was the only view more strongly held by the associated care professionals than by the RRS team. It was most commonly expressed by GPs and social workers. According to them, the tendency to use NRCH rather than keeping patients in their own home was problematic, especially because of their lack of capacity to provide cover over a large area with a 24 hours service.

The 'bias' towards placement in NRCH was also a complaint of the social workers. According to them, to provide follow-up care for discharged patients who received free NRCH care during the RRS episode was very difficult, because the RRS raised the expectations of the patients and their relatives. For example, patients and their relatives were sometimes annoyed with the charge for follow-up social care that had to be introduced after the RRS episode. Another factor that increased the expectations of the patients was the lack of assessment of the informal caregivers' ability to provide care. Such involvement in the RRS was however difficult, because keeping patients in their own home sometimes resulted in unbearable stress for the informal carers (which would have been avoided if the patients were in hospital).

The third most frequently reported negative feature of the RRS, the inappropriate patient criteria, has been recurrent in the findings and discussion. The overall conclusion must be that the inappropriate patient criteria, particularly the narrow range of acute medical problems that it provided for, has hindered the development of the RRS. The fourth most frequent negative feature was that it takes time for an innovative service based on multi-disciplinary work in a novel setting. There were many implementation problems associated with the collaborative work among various care professionals in a team, with inconsistent admissions, with the safety of staff when working in the community (especially at night), with publicity of the new service, and with collaboration with other care agencies.

In particular, many difficulties arose with the GPs involvement and collaboration. Some GPs strongly objected to the pressures placed on them by the RRS and by the shortage of acute hospital beds. They said that they were pressured to use the RRS because of the shortage and that some patients they had referred to the A&E were transferred to the RRS without proper medical assessment and consultation. This consequently increased the GPs workload. They sometimes were required to care for RRS patients who needed diagnostic tests and the attentions of a specialist. Meanwhile, they had to cope with relatives who complained that the sick older person 'would be better off in hospital', or that the patient had been transferred to the hospital in the middle of the RRS care episode. In addition, the occasional GP's neglect of their medical responsibility was another negative feature of the RRS.

Another aspect of joint work with other care professionals was that staff in NRCH and resource centres had communication problems with the RRS. These groups complained about the lack of patient information on admission and discharge, and that they were given too little time to assess the patients before admission. In addition, the multiple visits by many different professionals to the RRS patients within a couple of days of admission bothered the patients and the other residents. According to the GPs and NRCH staff, some patients were required to answer similar questions to many different care professionals. These findings indicate that there were various conflicts between the different groups of care professionals alongside the numerous advantages of working together.

Finally, the limited duration of care regardless of the patient's condition or recovery was controversial and a negative feature. This evaluation suggests that it is impractical to meet the needs of many older people in a fixed duration of care. Several negative features have been discussed. Some were similarly recognised by the different groups of care staff, but most were not. It is of concern that the care providers and service planners are largely unaware of these different views.

d) Opinions about the way forward for the RRS

Most of the staff's recommendations about alternative service developments related to avoiding the identified negative features of the RRS. There were however four predominant recommendations. First, the integration of the RRS with other intermediate care schemes (hospital-at-home, rehabilitation and recuperation services) was recommended to prevent the circulation of some patients who were not admitted and to save referral and assessment time. Second, the staff recommended working in partnership with A&E and the admission wards in the hospital to reduce the problems of the RRS with medical assessment, supervision and interventions by the patients' own GPs. Third, more rapid social service assessments and care package preparation was recommended through the hospital-based multidisciplinary team assessment, to prevent devaluing the existing hospital and community care services and to prevent duplicate care. Finally, the development of the RRS to respond to emergency social care needs rather than acute medical care needs was keenly recommended, especially by the GPs and social workers.

Chapter 11

A summary evaluation of the Barnsley RRS

During its first year, the Barnsley RRS successfully provided a valuable service for the town's older people. The RRS team members and other collaborative care professionals had never previously worked in this way and were unfamiliar with its requirements, but over a short period they steadily learnt from their experience and developed their practice to good effect. Although the new way of joint working brings many advantages to the patients, there were both teething and recurrent problems during the implementation, partly because of (a) the different setting for care compared to the hospital or primary care, (b) uncertainty about the best place to care for older people, (c) the imprecise eligibility criteria and guidelines, and (d) the time required to implement an innovative way of working in a novel setting. This chapter synthesises the findings from the empirical evaluation and makes recommendations about the way forward for the RRS.

11.1 The achievements of the RRS

The three most substantial achievements of the RRS were that: it provided a rapid response to the patient's needs through the multi-disciplinary care team's assessment and interventions (i.e. nursing care, occupational therapy, physiotherapy, social personal care, free residential or nursing care home placement, or aids and equipment service), it made a contribution to hospital admission avoidance, and it delivered care in people's homes or in a home-like environment.

Rapid response to the patient's needs

Many different care professionals as members of and collaborators with the RRS team were involved in the assessment and care of the patients during the RRS episodes and their follow-up. The involvement of multiple professionals in the short duration suggests that the RRS provided intensive care and many interventions. This is appropriate because to meet the needs of frail older people effectively, the contribution of many disciplines that straddle many professional boundaries is required (Luker, 1988; Costain and Warner, 1992). The timeless difficulty has been to co-ordinate such care and deliver it efficiently, but the initial evidence collected in this evaluation suggests that an RRS can make a valuable contribution. Adequate comprehensive multi-disciplinary assessment should be made before an older person decides about long-term care. While such assessments have been the norm for inpatients on geriatric wards, is by no means have they been guaranteed for patients on other hospital wards or in the community (Bennet *et al.*, 1995). Before the establishment of the RRS, frail older people in the community rarely received a comprehensive assessment, and some of those with multiple chronic illnesses or disabilities were inappropriately admitted to the town's acute hospital for support or care. The RRS's ability to provide a comprehensive multi-disciplinary team's assessment and intervention in a short time yielded brought benefits for both patients and several care services: the acute hospital, primary care and social services.

The patients' evaluation study compared post-care episode service use between RRS and hospital patients. It found significant differences in the use of respite care, home-delivered meals, and the neighbourhood support service. RRS patients were broadly more likely to be referred to and to receive many different health and social care services. These results reflect the greater frailty and dependence on others for ADL and IADL of RRS patients, and strongly support the finding that the rapid multi-disciplinary RRS team assessment provides quick access to health and social care support, especially for those with chronic disabling conditions. It may also save hospital beds, by avoiding subsequent admissions of the patients whose care needs are more comprehensively met after and as a result of the RRS episode. Overall, the RRS was the 'shop front' for the geriatric service and formed a bridge between the hospital and the community.

Hospital admission avoidance

The RRS aims to respond to sub-acute crises (although a large proportion of the RRS patients had chronic illnesses or disabilities on admission). These were medical problems that, if not addressed, were likely later to require an admission to hospital. Examples included, increasing shortness of breath due to chronic obstructive pulmonary disease and asthma, multiple falls, cellulites, deep-vein thrombosis (DVT), chest infection and cerebro-vascular accident (CVA) extension and transient ischaemic attack (TIA). Even minor changes or problems may lead to a break down in the patient's caring network and lead to hospital admission. It is widely recognized that assessment of the frail patient in an accident and emergency (A&E) department is difficult (Sanders and Morley, 1993), particularly a multi-disciplinary functional assessment. A&E also has dangers for the older person, such as delays, immobility, pressure ulcer development and iatrogenic complications (*i.e.* cross-infection).

Moreover, there was evidence that a substantial number of older people with chronic disabled conditions who needed assessment for and access to community and primary health and social care services, had previously sought care support from the acute hospital. They have been often called 'bed blockers'. Many such patients were referred to and accepted by the RRS. Consequently, there is little doubt that the RRS contributes to the prevention of hospital admissions although this evaluation study has not been able to assemble the range of controlled-comparison or 'before and after' data that is required to estimate the size of the effect.

The delivery of care in a home-like environment

The RRS provides the capability to assess and observe an older person in a non-threatening environment, allowing the formulation of appropriate and comprehensive interventions. These were fostered by liaison with the primary care team and by effective working with social services (in the provision of packages of 'community care'). Many RRS patients received its care in their own homes, at a primary care resource centre, or in a residential or nursing home. The home or home-like environments may have increased the satisfaction of the patients with their care. RRS patients was significantly more satisfied with the level of respect for their privacy than hospital patients, although some RRS were dissatisfied with aspects of personal care, particularly that its delivery was conditioned by the convenience of the service provider. The staff evaluation study found that the majority of care staff believe that one of the RRS's strengths is to provide care in a home-like environment, which enables the patient to maintain independency and privacy.

11.2 Implementation problems

There were many implementation problems and substantial difficulties associated with the innovative joint working in different care settings, although the RRS team members were motivated and keen to improve the service.

Lack of publicity about a new service

Among the RRS-associated care professionals, only 37% had become aware of the RRS within one month of its establishment. That percentage increased to 74 within seven months of its establishment. In the staff survey, several of the opinions about the weaknesses of the RRS can be partly explained by the inadequate information about the new service and the low level of knowledge about it. Many GPs and social workers said that they did not have 'proper' information about the services and called the RRS a 'word-of-mouth' scheme. Some social workers added that the local GPs seemed unaware that they could refer to the RRS and that it often took a long time for them to begin referrals. These findings suggest that it takes a considerable time to inform care professionals about the role and operation of a new service, and that poor information dissemination hinders the operation of a service.

Inconsistent and inappropriate referrals

Most patients were referred to the RRS by general practitioners (GPs) and hospital staff. As is found in other care services, a strong seasonal pattern to the number of referrals was observed. Of the referred patients not admitted to the care scheme, 60% did not meet the service criteria. The proportion of referrals by different groups of health professionals that were accepted fluctuated over the year. In particular, the non-acceptance rate of the hospital staff's referrals gradually increased. Nevertheless, only a low percentage of referrals by hospital staff were transferred to the acute hospital in the middle of the care episode, while the patients referred by the GP were the most frequently transferred. Overall, the differential acceptance and transfer rates suggest that GPs' recommendations carried more weight than those made by other health professionals but were less 'appropriate'. The statistical evidence suggests that GPs had a relatively high rate of referral of patients to the RRS who were too ill to be cared for by the team.

Disagreements about patient eligibility between the RRS team and referrers

The interpretation of 'eligibility' to the Barnsley RRS scheme was disputed throughout the year between the team members and the referrers. Many referrals of patients with a social problem were caused by the unavailability of formal or informal care, reduced mobility, chronic illness (without an acute medical problem), or a mental health problem. Some referred patients were too ill to be cared for by the RRS team, while some referrers attempted to use RRS as respite care. Referrals for such patients peaked on Friday evenings and bank holidays. There was widespread and persistent misunderstanding about the eligibility criteria among referrers.

In fact, the staff evaluation study demonstrated the different views about the problems to which RRS could appropriately respond. In particular, there was almost complete disagreement between the service providers and the referrers about the RRS's suitability for patients with emergency social problems and mental health problems. GPs were the most likely to disagree with the views of the RRS team. In particular, GPs were most likely to think that problems dissociated from acute physical health problems were appropriate for the RRS, while the RRS team were most likely to hold the inverse view. As discussed earlier, these large differences were a leading cause of the difficulties in collaborative working between the RRS team and other care professionals. GPs applied many criteria in their referrals: the medical condition of the patient, and her or his (or family) agreement, age and functional ability, the availability of an informal carer, cognitive ability, and the capacity of the RRS. Several of these criteria are irrelevant when referring a patient to the hospital. It suggests that the GPs, the main referrers to the RRS, did not believe that the RRS was a substitute for hospital care.

As discussed in Chapter 9, the hypotheses that: (a) there is an age difference between RRS and hospital patients (RRS patients are older than hospital patients), and (b) that RRS patients have more severe functional problems than hospital patients, were confirmed. The referrers took into account the patients' age and functional ability. In other words, the GPs tended to refer relatively old people with more severe functional problems to the RRS, and relatively young elderly people with fewer functional problems (and maybe acute medical problems) to the hospital. This raises the possibility that one effect of the RRS was that older people had a decreased chance of being appropriately cared for in hospital.

Furthermore, the staff evaluation study found strongly disparate views about the RRS amongst the RRS team, GPs and other care professionals. The RRS team strongly believed that many of the referrals were inappropriate, because they were cases of social or long-term medical problems. On the other hand, GPs tended to believe that patients with social or long-term problems were appropriate. These findings suggest that the providers' and the referrers' understanding of the patient eligibility criteria differed considerably.

Medical cover by the patient's own GP

GPs were (and are) normally informed on the telephone by the RRS team about the patient's medical states, care and discharge plans. A medical assessment or decision for a medical intervention is however required when the patient's condition has deteriorated, or another medical problem presents. Either the lack of GPs' time for the extra RRS work, or the lack of the GPs' commitment of the service, caused problems with medical assessments and interventions for RRS patients. Indeed, many difficulties arose with GP involvement and collaboration. Subsequently, inappropriate medical care prompted strong complaints by the RRS patients, especially among those who were transferred to the acute hospital in the middle of the care episode. Some patients wanted the GP to be more involved during and after the RRS care.

On the other hand, some GPs were very dissatisfied with the increased workload without appropriate compensation, while others were keen to explain that their problem was less financial reimbursement than the time demands. Furthermore, some GPs strongly objected to the pressures placed on them by the RRS and by the shortage of acute hospital beds. They said that they were pressured to use the RRS because of the shortage and that some patients they had referred to the A&E were transferred to the RRS without proper medical assessment and consultation. This consequently increased the GPs' workload. They sometimes were required to care for RRS patients who needed diagnostic tests and the attentions of a specialist. Meanwhile, they had to cope with relatives who complained that the sick older person 'would be better off in hospital', or that the patient had been transferred to the hospital in the middle of the RRS care episode.

It has been suggested that the rate of unplanned (re)admissions is an indicator of the quality of care (Victor and Jeffries, 1995). The high percentage of RRS patients being (re)admitted to hospital additionally suggests that the needs of patients with acute medical care needs were not met during the care episode.

Limited duration

The duration of the care episode was a function of the patients' placements and the scheme's capacities rather than the patients' needs. It should be remembered that the maximum permitted duration of RRS care was seven days for care in the patients' own homes, and 14 days for care in a resource centre or nursing and residential care home (NRCH). The limitation of the care episode was not for the benefit of the admitted service users but to maximise the number of people with a sub-acute need that the RRS could help. In these circumstances, there were inevitably a considerable number of RRS patients who needed continuing care or support at discharge. The staff evaluation study found that the limited duration of care, regardless of the patient's condition or recovery, was controversial and a negative feature. This evaluation suggests that it is impractical to meet the needs of many older people in a fixed care duration. The patients' satisfaction evaluation study also found that some patients were very disappointed with the short duration of the RRS care.

Some people believe that high readmission rates are 'the price for shorter in-patient stay' (Jones 1985; Pearson *et al.*, 2002). It is clear that the rate of (re)admission to hospital among RRS patients (19.6% within 28 days of discharge) was considerably higher than for Barnsley District General hospital patients (11.4% in 1998) or for hospital patients in other regions (15% Tierney and Worth, 1995; 13.2% Pearson *et al.*, 2002). Their continuing needs had to be addressed.

Communication and collaboration problems

Unfamiliarity with working closely together among the RRS team members, and between the RRS team and other collaborative care professionals, raised problems of communication. Although RRS was provided by a multi-disciplinary team during the first few months, the members to a large extent worked independently. The importance of working together and of more communication became very clear. There was also a lack of communication between the RRS team and other collaborative care professionals. Some who had been patients refused by the RRS team were repeatedly referred to the RRS by another referrer, either from the same care service or from a different care service. Consequently, some patients circulated from service to service, partly as a result of poor communication between the care professionals.

Furthermore, the staff evaluation study found that staff in NRCH and resource centres also had communication problems with the RRS. These groups complained about the lack of patient information on admission and discharge, and that they were given too little time to assess the patients before admission.

There were some problems with working with independent sector private nursing and residential care homes (NRCH). Some patients and their families who had care at a NRCH during the RRS care episode were dissatisfied with the poor quality of care that they associated variously with a shortage of staff, their incompetence, the inconvenient buildings, or the poor environment or interventions in the care home. In addition, NRCH staff were dissatisfied and found that the multiple visits by many different professionals to the RRS patients in a couple of days of admission bothered the patients and the other residents.

A lack of clarity about the payment arrangements and the availability of prosthetic equipment as between the RRS and other agencies led to misunderstanding and inconvenience. Associated calls on their limited finance raised concerns among the managers of the primary care services. There were recurrent conflicts about the provision of equipment and material supplies between the RRS and other services. Some collaborative care professionals held the extreme view that the RRS wasted scarce resources, or, more specifically, decreased the resources for the local authority community care team that had been an effective interface between the NHS and social services. These findings indicate that unanticipated conflicts between the different groups of care professionals arose alongside the numerous advantages of working together.

Problems with the placement rules

There were many recurrent problems with the patients' placements for RRS care. Although to provide care in a patient's own home has numerous advantages (e.g. helping patients to adjust to independent living, lower costs for the service through the greater involvement of informal care-givers and avoiding care-home fees), the capacity of the RRS, patients' conditions, and the availability of informal caregivers often prevented the provision of care in the patients' own homes. Nevertheless, there were many negative comments amongst the different groups of care professionals about RRS placements in NRCH. These were most commonly expressed by GPs and social workers. According to them, the tendency to use NRCH rather than keeping patients in their own home was problematic, especially because of their lack of capacity to provide 24 hours cover over a large area.

The 'bias' towards placement in NRCH was also a complaint of the social workers. It was difficult for them to provide follow-up care for discharged patients who had received free NRCH care during the RRS episode, because the RRS raised the expectations of the patients and their relatives. For example, patients and their relatives were sometimes annoyed by the fees for follow-up social care after the RRS episode. It was also observed that some RRS patients who were positive about their care in a care home were very likely to become a permanent resident in that (or another) care home after the RRS episode.

Some care professionals observed that the expectations of the patients were raised by the lack of assessment of the informal caregivers' ability to provide care. Such involvement in the RRS was however difficult, because keeping patients in their own home sometimes resulted in unbearable stress for the informal carers (which would have been avoided if the patients were in hospital).

The RRS team were particularly keen to place patients according to their preferences, especially when the patients' preferred location and the GP's catchment area were different. Besides, some independent patients without a mental health problem were dissatisfied with their placement in a care home. Most nursing home or residential care homes in Barnsley admit both physically and mentally unwell residents, so some mentally independent patients found themselves for the first time living alongside those with cognitive deficits.

Staff management

While a small number of staff provided a 24 hour service, the difficulties with maintaining the planned capacity, especially when staff were sick, on holiday or had resigned were also repeatedly discussed, as was securing the staff's safety in the different working settings. Another implementation problem was that inconsistently provided medical interventions came about through staff management problems and delayed staff training due to the lack of resources.

Recording and management

There have been persistent disagreements between management and staff about operational records. RRS first used the recording systems developed and used by the district nurse service. The separate records for nurses, therapists and social workers entailed much duplication, but the new 'single assessment' meant that some useful information was omitted, and other information unnecessarily documented. Inappropriate management of the patients' records has also occurred. Some records went missing at patients' homes, and some papers were kept haphazardly during the first months. With the growing size of the team, the problems described above magnified. It was therefore decided in October 2001 to develop the scheme's own patients' record system. It took many weeks to agree the content and design of the forms. Although the new system is simpler than the previous procedures it took a long time for the staff to get used to the changes.

11.3 Recommendations

The main recommendations are about the eligibility of service users, the response to the needs of older people, the need for intense collaboration, medical assessment and interventions, and for clear and consistent guidelines and support. From the evaluation studies, the main recommendations are about:

- **Patient-centred service-user criteria**
- **Designing the service to meet the needs of older people**
- **Improved communication and collaboration**
- **Improvement of medical assessment and interventions**
- **Clear and consistent guidelines and support**

Patient-centred service-user criteria

One of the purposes of the RRS, as with other.intermediate care schemes, is to prevent 'avoidable' hospital presentations and admissions. It has been claimed that 20% of hospital inpatient days for older patients in England and Wales are 'inappropriate' (National Health Service Executive, 2000). Older people who need rapid assessment for and access to community and primary health care and social services, who need rehabilitation services, or who suffer rapid deterioration, may be among the 20% of alleged inappropriate admissions. There is no sharp break between acute and chronic health disorders. The patients in question are often described as 'bed blockers' in the acute hospital. Whichever inference is correct, it is essential that the care needs of those people should be met by appropriate care services through either acute hospital or innovative community-based care services.

This reality has led to the growth of interest in 'intermediate care' schemes, although their definition and form vary (Steiner, 1997). There is also widespread interest in creating services that help to avoid or reduce periods of hospitalization. In fact, the aim of the RRS, as defined by Barnsley Health Authority and Barnsley Social Services (2000), was to prevent admissions to hospital. Before the RRS was established, some patients who needed rapid assessment for and access to community, primary, social or rehabilitation services would have been admitted to acute hospital beds.

As it turned out, the RRS has provided services to not only patients who would have been admitted to hospital, but also to many older people with a need for district nursing care, social care, support and respite care. The main reason for the use of the RRS by such 'unintended' patient groups may have been because the eligibility criteria were vague or inconsistently applied by the service providers and referrers. The third criterion emphasises cure from medical illnesses, while the other criteria are too vague to apply in practice. The vagueness appears to have allowed a gap in understanding of the eligibility criteria between the service team and the referrers to persist, which caused many and recurrent difficulties. It produced, for example, inconsistent decisions on referrals, which in turn confused referrers about which patients to refer. More generally, it produced mutual misunderstanding between the service team and the referrers. The RRS team members by and large understood that the service was only for patients with acute medical problems, and the referrers were more likely to understand that the RRS should be for people with social or district nursing care needs. However, the referrers, especially GPs, rarely referred patients with acute medical problems, because they believed that the RRS had inadequate diagnostic and therapeutic capacities – a view expressed by MacMahon (2001). It means that there is considerable disagreement between the RRS team and collaborative care professionals on the patient eligibility criteria and service aims.

Consequently, a priority should be to reduce the misunderstanding amongst service team members and between the service provider and the referrers about the eligibility criteria. Clearer and agreed criteria will empower the RRS team member at the referral point. The findings from the evaluation studies suggest that creating an alternative to acute hospital care may not be feasible for acutely ill older people, and that there are numerous older people whose needs are not met by the current acute hospital and primary care services. Apart from saving some hospital admissions and bed-days, it was found that an important achievement of the RRS is to provide assessment and care to a previously under-served group of patients with chronic health and functioning problems. Perhaps the two issues (saving beds and meeting needs) should be dealt with separately and met by different types of care services. The findings support a strong recommendation that the RRS should elaborate the criteria of eligibility for its service, away from the narrow range of acute problems towards a 'bridge role' between acute and primary care.

Designing the service to meet the needs of older people

It has been suggested that the unplanned readmission rate is an indicator of the quality of care (Victor and Jeffries 1985), and that high readmission rates are 'the price for shorter in-patient stay' (Jones 1985; Pearson *et al.* 2002). Accordingly, one of the reasons why the rate of readmission to hospital after RRS episodes (19.6% within 28 days of discharge) was considerably higher than that of hospital patients (15% Tierney and Worth 1995; 13.2% Person *et al.* 2002) may be because the duration of the RRS care is limited by an administrative rule rather than the needs of older patients. Although the limited duration avoids problems with waiting lists, and enables RRS to respond swiftly to the needs of service users, the needs of older patients who are prematurely discharged and need more care or support are not met by the RRS. Unless the limited duration of care is removed, the RRS cannot be an alternative to hospital care. Accordingly to achieve the aim of the service, the short maximum duration of care should be reconsidered.

Improved communication and collaboration

Some patients were circulated from service to service at the referral stage because of disputes about eligibility. Fundamentally, the disputes were caused by the unclear and alternative care pathways for frail older people and by budget restrictions and resource disputes among the services. Numerous problems of sharing the resources and caring responsibilities between services were revealed. The RRS also had difficulty with resourcing staff training and with sharing equipment. To reduce these limitations, more intense collaboration between care services for older people and mutual agreements and effective communications among all those involved in complex care pathways for the frail older people are required.

Improvement of medical assessment and intervention

According to MacMahon (2001), the common perception of 'intermediate care' is that its purpose is to avoid or reduce hospitalization. This raises the danger of ageist prejudice that prevents older people's access to correct diagnostic and therapeutic facilities. The high rate of readmission to hospital after RRS may have been associated with inappropriate medical investigations or interventions. Another causal factor may have been the lack of agreement by the patients' own GPs to take medical responsibility.

At the referral stage and especially during the care scheme, the majority of patients were not directly contacted. The discussion about a patient's care was mainly undertaken on the phone. In this procedure, the few issues considered are whether the medical intervention or investigation for the patients are appropriate, and whether the patients are only required to have that care by the patients' own GP. In fact, the level of dissatisfaction of the RRS patients with their medical care was remarkable. The RRS needs to consider other medical options for the patients, such as a doctor mandated to the service, or more linked work with A&E or the admission ward of the local acute hospital. Furthermore, as the GPs suggested, the unavailability of diagnostic tests and medical interventions limited the capacity of the RRS to care for patients with some acute or sub-acute illnesses. It is therefore necessary to develop rapid access to radiology and pathology to provide an immediate problem-solving pathway for RRS patients. Alternatively, the service needs to consider returning the prime responsibility for the medical care of the patients' to their GPs. Unfortunately, the findings from the current evaluation study cannot be used to specify the best solution. Therefore, the frequency and range of the medical investigations and interventions and also, whether the needs of patients are met by current service provision, need further examination.

Clear and consistent guideline and support

Although the service continuously learned and developed from its experience, at the outset there was a lack support and guidelines to implement the service. The RRS has overcome many problems, such as conflicts over referrals, protocols for acute medical interventions in the community, the pathways of care for the patients, recording and keeping documents, and the process of the assessment. Most especially, most staff were unfamiliar within innovative multi-disciplinary ways of working. It caused worries among the staff and affected their confidence. To reduce the problems, more appropriate and clear guidelines for the service are required at its inception.

Section IV

Implications for older people's service development

Chapter 12

Implications for service development in the UK

The rapid succession of contemporary reforms in care services for older people in the UK involves key changes in the organisation and delivery of care services for frail older people. While it is still too early to evaluate the outcomes, it remains unclear whether the reforms will establish a satisfactory and comprehensive system of treatment and care. More emergency hospital admissions and increased pressure on acute beds have been among the unintended outcomes of recent policy changes (especially the restraint in public expenditure on long-term care and the reduction in acute hospital beds). The prevailing emphasis upon the 'efficiency' of the NHS care system means that many older people with less severe or less acute illness are denied care in acute hospitals. Nor are their care needs entirely met by community-based primary care. Day care and domiciliary care packages have been slow to develop in the private sector, while the present funding arrangements in local authorities produce perverse incentives that encourage the use of residential and nursing home care and have accompanied cutbacks in the provision of domiciliary social care (Henwood and Wistow, 1999).

In the future, a greater number of households will consist of single old people or older couples without children. If they have illness or disability, community-based services are a questionable substitute for residential care. The ending of universal access to NHS long-term care for older people and the limited availability of home-based care have reduced the choices for consumers and their families, despite the consistently stated converse aim of care reforms. In many European countries, including the UK, the tendency has been for social care support to concentrate more and more on those with high dependency and care needs. Low intensity public sector services (e.g. home care, meals) have been progressively cut back in Barnsley as throughout the country and indeed in several northern European countries (Johansson, Sundstrom and Hassing, 2003). In the internal market for health care, GP practices that became fundholders were offered incentives to keep within 'cash limits'. This mirrored the concern of the government with rising public expenditure and their wish to improve defined expenditure limits. To remain within the limited budget, primary care providers became more discriminating in accepting patients (Victor, 1995). Older people are prominent consumers and users of primary care services, as especially home visits and prescribed medicines. Thus, older people, particularly those with multiple disabilities, found barriers to primary care. Not all those who were in greatest need of care were able to access care. Preventing older patients with chronic but sub-acute needs from occupying hospital beds was an urgent priority in the NHS. These and other factors, including the rising political sensitivity of NHS 'failures' arising from the ever more cynical media coverage, form the service development and policy contexts that have led to the promotion of 'intermediate care'. This chapter focuses on the implications of the empirical findings for UK policy and practice development and for further research into the appropriateness, adequacy and effectiveness of care, support and treatment services for older people.

12.1 Implications for the care service developments for older people

A comprehensive approach to health care delivery

The British National Health Service, like many other national health care systems, has not produced uniformly excellent health care for the older population. In the NHS of today, the common illnesses associated with old age and the number of older people with multiple degenerative conditions referred to hospital has increased, raising the care expectation of patients and their families. Unfortunately, acute general hospitals are not well suited to respond to the complex medical, functional and social assessment and care needs of this vulnerable group. Older patients are at high risk of hospital-obtained deterioration through infection, iatrogenic diseases and negligence. Although the system fails them at least in certain respects, they are branded as being unacceptable users of acute hospital beds (bed blockers) (McDonagh *et al.*, 2000). While a 'comprehensive assessment' has become the norm for inpatients on geriatric wards, it is by no means guaranteed for patients on other hospital wards or in the community (Bennet *et al.*, 1995). Therefore, the majority of frail older people with multiple chronic illness or disabilities rarely receive a comprehensive assessment or periodic comprehensive reviews of their multiple therapies and treatment and the associated provision of support. Inappropriate combinations of treatment (especially medication) leads to (avoidable) admissions to the acute hospital for support or care.

Some might assume that a patient's GP would provide an integrated or holistic approach to the older patient with multiple, chronic conditions, but as practices have expanded and become multi-disciplinary, in actuality comprehensive assessments are rarely undertaken. For this reason, the Department of Health has recently invested in several nurse-led initiatives to provide comprehensive reviews, including the *Evercare* scheme that has proved of value in the (very different) United States health care system (Kane and Huck, 2000).

In this context, new and innovative models of care for acutely or sub acutely ill older people that provide alternatives to acute hospital care are attractive to health service planners and politicians and are being introduced in the UK. This is one of the key changes to the provision of health services to older people of the last few years. Such innovative practice schemes have been controversial. Most of the substitutes aspire either to avoid admission to hospital, or to support discharge from hospital, or to develop innovative models of community care. None exclusively employ either acute hospital care or primary care, but rather they bridge acute and primary care and are therefore known as 'Intermediate Care'. Its Intermediate Care say that it provides individualized, patient-centred care at or near to the patient's home, which ensures timely and appropriate access to acute, rehabilitative and long-term care services, and uses a whole-systems approach (Roe *et al.*, 2003; Kernick, 2003). The findings of this study have indeed demonstrated that older people benefit from comprehensive, multidisciplinary assessment and a holistic and rehabilitative approach to health care delivery. Many older patients certainly prefer to receive their health care at or near to home.

Equal access to health care

However, if acute treatment is required and older people need hospital care, it should be provided. In addition, ill older people should not be discharged prematurely from hospital care 'to save beds'. Detractors of intermediate care say that it is a 'quick fix' solution to the shortage of hospital beds and to the scarcity of nursing home places in the community. Nonetheless, when discussing patient eligibility for intermediate care services, the intrinsic ageism of the NHS becomes obvious. Bulger (2002) said that a 75 year old patient who is unsteady and has a chest infection is typically regarded as the model of a patient who can cope in their own home. In contrast, a 35 year old patient with pneumonia is regarded as a legitimate hospital case. Although the older patient is likely to have multiple medical problems, they are likely to be directed away from the "hi-tech" hospital environment. Also, a fall in a young adult is often called a 'collapse' and treated differently from a similar event occurring to an older person.

Quality of intermediate care

Concerns about the quality of delivered intermediate care have recently increased. As yet there is no clear evidence that these initiatives meet the care needs of frail older people as specified in their aims. Some commentators envisage a return to the discredited ethos and practices of the workhouse wards (diagnostic failures, inadequate treatment and rehabilitation, long stays, complications) while some health service planners worry that the spate of intermediate care initiatives will produce escalating costs for care of unproven effectiveness. They have, for example, made more use of private nursing homes, raising concerns about the standards of care. The *Care Standards Act 2000* and the creation of the National Care Standards Commission and several related bodies under the government's Social Care Quality Initiative raises the prospect of more effective regulation and a rise of minimum standards in care delivery, but whether these measures have an enduring positive effect will depend greatly on the level of funding and shifting government priorities. At the very least, there is now a clear need for reliable methods monitoring the quality of care associated with service development. As Carpenter *et al.* (2002) commented, local schemes should be compared against nationally agreed standards of care.

Effective resource management and interprofessional collaboration

More effective resources management requires improved technological support for medical investigations and treatments in the NHS. Important goals of intermediate care are to overcome the barriers between doctors and other care professionals, between social and health services, and between statutory and non-statutory services, and to smooth the interfaces throughout the system (Vaughan and Lathlean, 1999). A pervasive problem, nonetheless, is that existing care staff are unfamiliar with innovative ways of working. Therefore, appropriate care staff training for multi-disciplinary work should be provided to enable staff (including geriatricians, nurses, general practitioners, professionals allied to medicine, and social care staff) to work in new ways and more collaboratively. In addition, some need to improve their skills in the assessment and management of frail older people. All have to re-cast their professional structures and attitudes and overcome institutional and professional barriers to develop efficient and flexible multidisciplinary community-based teams (Carpenter *et al.*, 2002).

Innovative practice and evidence based health care

Most intermediate care initiatives are delivered by nurse-led multi-disciplinary teams. As intermediate care expands, it is becoming necessary to consider the professional, ethical and legal implications of the new allocations of responsibilities amongst the team members. In particular, the current developments confront the essence and scope of nursing practice (DoH, 2000b). The majority of intermediate care initiatives need staff with improved assessment and high level practice skills to deliver patient-focused services (UKCC, 1998; Clegg, 2001). National health policy has encouraged development of the nurses' role, and the professional bodies have collaborated in the extension of their practice. The aspiration of many nurses working in intermediate care to take the leading role is certainly making a difference. The more complex and challenging that nursing practice becomes, the more nurses must be aware of the professional, ethical and legal implications of their work (Humphris, 1998). For example, the risks involved in nurses developing advanced geriatric assessment skills must be specified and minimised. Information is required about what nurses can and cannot competently do (Clegg, 2001). Care providers and researchers need to ensure that detailed evidence informs the development of (medical and nursing) practice. Developing practice initiatives with medical colleagues, such as advanced geriatric assessment skills for nurses to provide hospital avoidance schemes for frail older patients, are perfect opportunities for collaboration in service development.

Innovative education and training and sharing experience

The findings of the evaluation of the Barnsley Rapid Response Service have highlighted the importance of communication, collaboration, co-ordination and evaluation in multidisciplinary team working with frail older people, and showed continuing concerns about professionals' communication with each other. In response to these concerns, it is recommended that new courses of education and training are developed and resourced to provide the necessary knowledge and the required skills in management, information and technology, team working, communication, participation and patient communication.

Many similar intermediate care services have been established throughout the country, although the form and extent of the provision have varied greatly, including the criteria for eligible clients, the boundaries of the multidisciplinary teamwork, the duration of a care episode, and the speed of development of the services. Similar developments are taking place in other countries (e.g. sub-acute care schemes in the USA) (Griffiths, 2002). Despite the proliferation, in Barnsley there was little effort to learn from other schemes and to avoid predictable mistakes even from nearby services in the region. The new intermediate care services should not just take a single model and 'make it' work but pay close attention to what is already known and identify the critical features that produce the desired changes. As exact replication is impractical, and it is only a first step to identify a scheme that worked elsewhere (or indeed did not). To understand why such an intervention was effective, it is necessary to identify the enabling conditions.

Towards the integration of intermediate care services with existing provision

Intermediate care schemes must avoid inefficient duplication in a system starved of resources (Hadridge and Newman, 1997). The schemes must not make the system more costly (without expanding or improving services) or mainly provide lower quality alternatives to existing services. However, if intermediate care improves or increases services for older people, the increased expenditure will be vulnerable unless it can be shown through performance measures to offer good value. In fact, it would be another kind of ageism if a service innovation was stopped simply because it increased costs. A sophisticated approach to improving outputs and efficiency in the NHS that takes into account costs and patient benefits. Presently, however, comparisons of existing services with intermediate care service are impossible because neither the data nor the methodologies are available. In contrast with the waiting list, which is typically a crude approach to deferring demand, intermediate care can be used as a better way of managing demand (Edwards and Hensher, 1998). Successful and significant features of schemes for intermediate care only develop when comprehensive assessments are avoided in other care sectors which are therefore failing to meet the care needs of older people.

Nevertheless, as indicated by the Barnsley evaluation, many frail older people's needs are not met by the current RRS and some patients continued to be shunted from service to service. The staff's main recommendation to avoid these problems was to integrate the local 'intermediate care' schemes (hospital-at-home, rehabilitation and recuperation services) and to work in partnership with A&E. In other words, they believed that a single point of contact or 'assessment centre' should be created that does not exclude rapid access to hospital and non-hospital alternatives. Additionally, clear standards and practice guidance are required. Without such clarity, it will never be possible to assess the effectiveness of intermediate care schemes, and the contributions of the various professionals will always be hard to integrate.

12.2 Implications for further research

As yet there is insufficient evidence about whether intermediate care schemes are cheaper than traditional care services, while their cost-effectiveness remains completely unknown. There has been little consideration of whether home-based intermediate care services are acceptable to either patients or informal carers. The extra burden and responsibility produced by discharging patients 'sicker and quicker' from hospitals may place informal carers under intolerable stress. Overall, the current evidence about intermediate care services is too fragmentary and weak to support general conclusions or to feed back into new service provision. More research and evaluation are therefore needed. The optimal scale or nature of service provision requires further investigation.

As mentioned in Chapter 6, a national evaluation study of the costs and outcomes of intermediate care services for older people was commissioned by the Department of Health. Nonetheless, intermediate care schemes are geographically very variable and it will take a considerable time to complete the national evaluation study. It appears increasingly likely that the national studies will produce only broad 'main outcomes' comparisons, and will capture little of the numerous changes, problems and benefits experienced by both patients and providers. Consequently, a very strong case can be made for local evaluation studies.

The most powerful and prestigious methodology in clinical health services research is the randomized control trial. Its strengths are in some fields over-interpreted, while some health services researchers reject its role (Prescott *et al.*, 1999). This evaluation of one RRS has indicated that matching RRS and acute patients by the main clinical problem is not feasible. Similarly, a randomised controlled trial (RCT) may be impossible or undesirable.

The generalisability of RCT evidence may be limited because the study sample may not be representative of the population. As shown in empirical studies, it is hard to carry out a study of sufficient size to accomplish sufficient power to detect significant difference in outcome. Moreover, the variation in skill mix, staffing levels and many other confounders may indicate that it is not easy to assume negative or positive trials. Randomization also considerably increases the task of gaining informed consent. Nonetheless, national studies on the evaluation of intermediate care schemes are likely to rely on RCTs. Since the intermediate care has been developed in UK every health district (1999/2000), most schemes may have therefore very little evaluation.

Thus, descriptive, monitoring and local studies should be strongly encouraged. They would be able to support or refute findings identified in national randomized control studies, identify otherwise unmeasured outcomes, and help to explain the findings of randomized studies. The combination of these research techniques may overcome many limitations of the stand-alone randomized control trial.

Further study is required to explore more comprehensively the impact of the intermediate care schemes on older patients, rather than concentrating on whether they can save acute hospital beds. For example, it will be valuable to explore the distinctive impact of the assessment and intervention by the multidisciplinary team, as differentiated from existing community health and social care, on which groups of older people derive most benefit from this service.

Most intermediate care schemes limit the duration of the care episode by the schemes' capacities rather than the patients' needs. The limitation of the care episode is not for the benefit of the service users but to maximise the number of people with a sub-acute need that are helped. As a result, many patients inevitably need more care or support at discharge than intermediate care schemes provide. As shown in the findings of empirical studies, the limited duration of care, regardless of the patient's condition or recovery, was controversial and a negative feature. This evaluation suggests further research on the impact of the limited duration of the care episode on the service users. It also recommends a longitudinal study to address the question: "Does intermediate care improve older people's health status in comparison to 'traditional' older people's services?"

In addition, most intermediate care schemes aim to provide alternatives to acute care. As empirical studies have found, the care schemes generally expect informal caregivers to be more involved in the care of patients than does acute hospital care. Such involvement in the care was however difficult for the carers, because keeping patients in their own home sometimes resulted in unbearable stress (which would have been avoided if the patients were in hospital). It is therefore strongly recommended that there is more study of the effects of alternatives to acute care on informal caregivers.

Finally, as found in the staff evaluation study, there were strong and disparate views about the hospital avoidance care scheme amongst service provider agencies and care professionals. The different views lead to conflicts about the delivery of the service. Moreover, as revealed by the experience of the Barnsley RRS in the first year (Chapter 8), although the new way of working and sharing brought many advantages to the patients, professional care staff had never previously worked in this way and were unfamiliar with its requirements. This resulted in both teething and recurrent problems in the implementation of the service. It is likely that all intermediate care schemes will increase the need for staff training to work in new ways and more collaboratively and to improve skills in the assessment and management of frail older-people. There should therefore be more research on the aptitude of different grades and professions of staff for acquiring new skills and taking on additional responsibilities.

In conclusion, the RRS demonstrated a need for a rapid response that provided holistic multidisciplinary assessment and had the ability to (re)organize patterns of support and treatment. Many older people with multiple chronic illness or disabilities certainly benefit from the holistic multidisciplinary approach to care delivery, and prefer to receive their health care at or near to home. The ability of RRS to bring about radical and permanent change was limited by the qualified recognition and acceptance of the service by both GPs and hospital departments. If intermediate care schemes are to make a real difference, they need to be given greater capabilities and their 'powers' in relation to GPs and hospital physicians (as in referral decisions) need to be strengthened.

Chapter 13

Implications for service development in South Korea

The very rapid and radical transformations of South Korea's economy and society during recent decades and their impacts upon the care of frail older people were made clear in Chapter 2. It concluded that there is, and will continue to be, a need to elaborate and expand formal health and social services for sick and dependent older people, particularly those with multiple, chronic conditions. There will therefore be a need in South Korea for rapid innovation in these services, with direct implications for staff training, retraining and recruitment, not least to adapt to changed responsibilities and in new configurations of multi-disciplinary teams. This final chapter identifies some lessons for South Korea (and for other countries that have reached a similar stage of socioeconomic change and health and social service development) from the experience of introducing intermediate care, and specifically the Barnsley Rapid Response Service.

The changing arrangements for the support and care of older people have been produced not simply by population ageing but also by interacting economic, social and attitudinal transformations. Several commentators have described negative results for older people, but it would be more accurate to say that they have specifically affected a defined birth group or, in individual families, the particular generations whose expectations for their living situation and support in old age have been denied and disappointed. For them, the 'silent promise' has been broken: later generations and cohorts will not acquire the same expectations and will have more substantial assets and welfare entitlements. The severest impacts are on a 'transitional generation' of older people, most of whom have attained or will attain old age during the two or three decades each side of the millennium, whose eldest (or any) sons have broken the sequence expected by the inter-generational understanding. The similar changes in western Europe were spread over up to five generations, but in South Korea, the transformation has impacted on one or two generations of the nation's older people.

Socio-demographic trends

As occurred earlier in developed western countries, the characteristics of the older population in South Korea are changing, while several broad features observed elsewhere are apparent. Gender differences in the older population are substantial, for example women outlive men but tend to experience both earlier and greater disability. Other differentials are that a much higher proportion of men than women are married among the older population. This has huge implications for support in old age, for men are more likely to have a spouse if support is required. On the other hand, older women are more likely to be widowed, to live alone, and to have poor health and low income. Other key factors have been the decline in fertility and a high divorce rate. The consequent changes in the patterns of family life have important implications on the availability of informal care.

Unfortunately there are no national studies of the health and disability status of older people in South Korea. It is therefore impossible to describe age-specific trends in either physical or cognitive disability or the need for support. The massive reduction in mortality rates and the great improvement in the material standard of life (including in housing and sanitary conditions) has almost certainly been accompanied by a reduction in infections disease and deficient nutrition, and taken the country into the second phase of the 'epidemiological transition' during which degenerative disorders, especially cancers and circulatory and heart disease, become more important as causes of death. Whether the net effect has been to increase dependency at any old age is not known.

Epidemiological studies in other developed countries have repeatedly shown that the prevalence of chronic disorders and disability increases exponentially from early old age (say 60 years), and climbs steeply after 75 years of age. A recent British study indicated that very older people are likely to have a long-standing illness which limits their activities, to be more dependent, to have more functional difficulties, and to receive more formal care services (Tinker *et al.*, 2001). Such findings are important for South Korea, where the number reaching the oldest ages in growing fast.

In projecting future levels of disability and demands for care and support, however, an elementary mistake is often made. It cannot be assumed, especially in a society undergoing rapid social and health service changes, that age-specific rates of disability will be constant. The number aged, say, 75-79 years may increase, but the prevalence of disability among them may decrease. Very recent United States studies based on national health status surveys have reported reductions in age-specific disability (Crimmins *et al.*, 1999; Manton *et al.*, 1997, 1998). The United Kingdom confronted the demands generated by a combination of an increasing older population and rising care and treatment expectations earlier than South Korea. Indeed, the UK pioneered many care services for frail and dependent older people. Today the United Kingdom has a comparatively well developed range of care services for older people, while South Korea is in the early states of their development.

Increasing and diverse needs of chronic disabled older people

As mentioned in Chapter 4 on the residential and financial status of older people, it is hard to make a definite prediction but most commentators expect rising income and health inequalities in Korea. It is likely that more older people will be affluent and that many more will live alone. They will be also better 'informed' about health and health–care provision and facilities. However, there will be a rising proportion who will remain financially deprived. The absolute increase in the number of the very old would certainly impinge on the needs for various health and social service provisions (Eachus *et al.*, 1996). In addition, as more people become gradually more aware of their 'rights', the expression of such needs, *i.e.* their demands, will also increase (Banergee, 1996).

Progress in medical research has raised hopes of cures for many hitherto disabling and incurable conditions (Banerjee, 1996). In Britain, there has been substantial expansion of orthopaedic, vascular, ophthalmic, renal and cardiac services (Royal College of Physicians (RCP, 1991). Many older people do not always get comprehensive access to the newest high-tech medical facilities which are available to the young (RCP, 1991), although there are signs of better and increased service provision (Mulkerrin, 1994). This is the reason why the NHS *National Service Framework for Older People's Services* places considerable emphasis on ending age discrimination in their delivery. Despite the advances of high-tech medicine, many elderly people still have disabling conditions such as stroke disorders, arthritis and Parkinson's disease. The high-tech medicine has changed and will continue to develop. New high-tech therapies may result in more patients with chronic disabling conditions, or, more generally, alter current rates of disability by age and sex. In addition, there will be growing demands for 'informed choice' and changed expectations in the population about how their health and health care are managed.

The growth of unmet needs health care system dominated by 'cure' not 'care'

In South Korea, nonetheless, current health care services for frail older people fail to meet their needs. The development of health and welfare services has to date been deeply influenced by the structure, priorities and divisions among the welfare and medical professions. The dominant influence of physicians has contributed to a low priority for 'care' (rather than 'cure'), and for the rehabilitation and the management of chronic conditions. Even in the development of services for disabled older people, the focus has been on the expansion of acute medical facilities, while community care and rehabilitation, long-term care services, and personal social services have to date received little attention.

In these circumstances, the pressure will grow to increase the productivity (or intensity of use) of acute hospital beds. To reduce the problems deriving from the shortage of the available hospital beds, the average length of the episode will decrease and many older people who are less acutely ill (especially, chronically ill or disabled) will be seen as 'undesirable' patients. Alongside the problems of the shortage of available hospital beds, hospital Accident and Emergency (A&E) departments will also be pressured by increasing demand. Meanwhile, there will be growing numbers of chronically disabled older people who need support or care in the community. This sequence of events has been seen in many countries and almost certainly will recur in South Korea. The net result for frail older people will be an increase of the number of patients whose needs of health care are unmet by the health care services. At some point, the level of unmet needs will be perceived as unacceptable, which will lead first to demands for and later the political will to carry out reforms of the health care services.

Diverse service development to meet the different levels of care needs

From the 1960s to the early 1990s, the main concern of successive Korean governments was economic development, while the development of care services for older people had low priority. Fortunately, the current administration has shown a concern for and commitment to health and welfare issues including those dedicated to older people. Although care services for frail and sick older people have a relatively short history in South Korea, they have quickly developed but still have many limitations. Apart from acute hospital care and individual clinics (privately run by a GP or specialist), most of the care services are available only to those minorities of older people who either have very low incomes and are eligible for 'Livelihood Protection' or are very rich. The needs of the majority of frail older population are presently not being met.

There are too few residential places for physically and mentally-impaired old people, and a considerable proportion of the available places are luxurious and serve the rich. Presently, most western countries are prioritizing the development of home based services rather than residential services, to decrease the aggregate cost of 'elderly care' and to enhance the quality of the users' lives. The experience of western countries cautions against the dangers of concentrating on the development of residential or institutional care, but at this time there is undoubtedly an urgent need to increase provision. In the UK during the 1980s, a substantial growth in the number of nursing home places was stimulated by state financial support. It is possible that the same might happen in South Korea. A system of social insurance for long-term medical treatment is currently being considered to ease the growing difficulties of frail older people in South Korea. It may lead to a rapid expansion of residential care. The resulting problems of rapid growth might not only be rapidly increasing costs of care but also an increase of unmet needs through the high cost of supporting a small number and limited choice. Moreover, the number of frail older people who prematurely and inappropriately give up independent living would be increased. It is hoped that both residential and domiciliary support will be developed together, with their relative expansion adjusted to measures of need, the effectiveness of the two forms of supports, and the changing acceptance and preferences of socially isolated but dependent older people for living on their own with domiciliary support or for living in long-term care homes.

The experience of the UK and other European countries strongly suggests that South Korea should develop a range of domiciliary health and social care services alongside institutional care. The aim should be to support frail older people in their own homes where this is wished and cost-effective, and to meet the various level of older people's care needs. Furthermore, a scheme of comprehensive assessment for dependent older people' care needs, designed care plans and 'packages' should be introduced to ease access to and the delivery of services.

Comprehensive multidisciplinary team care and innovative education and training

As discussed in Chapter 3, health care in South Korea is provided mainly by independent medical practitioners and private sector organizations. They run more than 91% of all hospitals and clinics and employ 89% of all physicians. Most private hospitals and clinics are in urban areas and operate in a competitive market. Physicians have strongly influenced the development of health care services while the influence of other health professions, such as nurses, physiotherapists and occupational therapists remains weak. Consequently, the care services have been fragmented and delivered in an uneven way, and many frail older patients make numerous and fruitless visits to medical practitioner clinics to seek treatments for their chronic conditions. In particular, the problem of 'under-treating' older patients in rural areas has been increasing.

The evaluation of the Barnsley RRS and reviews of UK care services for frail older people suggest that to overcome these problems, South Korea should develop a comprehensive system of treatment and care for older patients with chronic health and functioning problems. The RRS provided comprehensive assessment and had the ability (and even more the potential) to (re)organize patterns of support and treatment. South Korea should consider establishing innovative intermediate care services with the ability to carry out comprehensive assessments and care planning. Such services may begin to overcome the fragmented services and encourage collaboration in planning and providing health and social care services through partnerships and joint investments.

A key hindrance to the development of a comprehensive approach to care for frail older people is that physicians have excessive influence in health services development. Few appreciate the capacities and strengths of multidisciplinary team care. Furthermore, as learnt from the RRS evaluation, widespread and persistent misunderstandings between professions hinders the development of a comprehensive approach to health care. Problems of communication, collaboration and co-ordination in multidisciplinary team working are frequent impediments. These findings strongly suggest that in South Korea new courses of education and training should be set up to develop the necessary knowledge and essential skills in management, information and technology, team working, communication, participation and patient communication. Similar training should be incorporated into medical training.

Quality of care

As well as the quantitative service shortfalls in Korea, there are concerns about the quality of many older people's services. The Ministry of Health and Welfare (2000b) has lately published standards and regulations for residential and nursing homes but most are unambitious. Other limitations of the existing health and social care system that compromise the quality of care include widespread public ignorance and misunderstanding about care services. In addition, most care services depend heavily on volunteer staff. As found in the UK, a system of registration and regular inspection of care-homes is necessary to secure the quality of the residents' lives, but this has not yet been set up in South Korea. Although such a system has been operational in the UK for many decades, as the role of the private sector in provision of long-term care has expanded the timeless concern about quality of care in these settings continues. It is clearly a never ending task to raise the standards of residential care. South Korea should address the task without delay.

The sector had been regulated in England and Wales by the *Registered Home Act 1984*, with a voluntary code of practice for residential and nursing homes (Centre for Policy on Ageing, 1996) and national guidelines for nursing homes. Nevertheless, the legislation and guidance concentrated mainly on the structural and process aspects of care, with less consideration of the quality of life of the residents. A main problem has been the inconsistent way in which guidance has been understood by the inspectors of the co-existing local authority and health authority units (Royal College of Nursing, 1994). This approach caused unacceptable differences in standards of care across the country, and much confusion for both service providers and service users.

National care standards were published in November 1999 for consultation and began to be implemented in April 2002. Others, such as staff qualification standards in care and residential homes are being introduced over time, in this case April 2004. Following furious protests from the industry, many physical standards were withdrawn within three months. The standards cover a home's physical environment, management, policies, staffing and information, the residents' rights, daily life, food and mealtimes, health and personal care, and death and dying. To address the variations in inspection processes and outcomes across the country, a new *National Care Standards Commission* took over the local authority and NHS 'registration and inspection units' responsibilities. In April 2004, it was renamed the *Commission for Social Care Inspection.*

South Korea can learn from the failings of the UK's former fragmented arrangements for the registration and regulation of residential and nursing home care. Thus, the imperative tasks for the Korean government and the country are not only to increase the numbers of residential care places, but also to set higher standards of care and to establish effective quality assurance systems through regulation and inspection. A single registration and inspection system should be established.

Implications for further research

This chapter has emphasised the need in Korea for expanded services for frail older people. However, little attention has been paid to the research that is required to describe the service needs of frail older people and their informal caregivers and to promote the quality and efficiency of care services. At present in South Korea, there is little information about the unmet care needs of older people and their informal caregivers. Moreover, the immense diversity in the available care services (as by regions of the country) has not been sufficiently examined and challenged. In particular, the unmet care needs of frail older people in rural areas have been neglected. It is essential to produce more evidence on these issues.

Lessons about the implementation difficulties of innovative services

As found in the staff evaluation study, there were strong differences of views about the Barnsley Rapid Response Service amongst the service providers and the collaborating care professionals, and these produced conflicts in the delivery of the service. Moreover, although the new way of working and sharing brought many advantages to the patients, professional carers had never previously worked in this way and were unfamiliar with its requirements. Thus, there were both teething and recurrent problems in the implementation of the service. These lessons strongly suggest a further study to identify the needs of care professionals when implementing a new service. The interpretation of 'eligibility' to the Barnsley RRS scheme was disputed throughout the year between the team members and the referrers. Other frequently discussed issues were the inconsistent capacity to provide medical interventions, the problems of staff management and delayed staff training (due to the lack of resources). There was widespread and persistent misunderstanding about the eligibility criteria among referrers.

While a small number of staff provided a 24 hour service, the difficulties with maintaining the planned capacity, especially when staff were sick, on holiday or had resigned were also persistent problems. Another was how to secure the staff's safety in the different working settings. Unfamiliarity with working close together among the RRS team members, and between the RRS team and the collaborating care professionals, raised problems of communication during the early months. Besides, there were many other recurrent problems with the patients' placements for care during the RRS episodes, with the recording and management of patient documents by a multidisciplinary team, with medical cover by the patient's own GPs, with lack of publicity about new service, and with inconsistent referrals to the service.

South Korea must therefore recognise that service development is not accomplished only by enthusiasm or an agreed plan. It is much more complicated and very difficult to implement a new service. Accordingly, careful advance planning and preparation are required for radically new care services in South Korea. Particular attention should be given to the specification of the new and changed responsibilities of different professionals and different grades of staff; to the procedures of communication and joint working; to the education and training of all staff who will work in and with the new service; to providing the necessary resource for training and the delivery of new assessment procedures and therapies; and to the production of good quality and effective information for the patients and general public. They should understand what exactly the new service provides and what it does not.

The wider lessons of the Barnsley RRS innovation

An important aim of the doctoral research has been to understand the processes and impacts of the adoption and implementation of an innovative health care service for frail older people. While it was not assumed that a British 'Rapid Response Service' or any other form of 'intermediate care' would *necessarily* be appropriate in South Korea, as Chapter 2 showed the rapid pace of modernisation and socio-economic change in the country has produced a situation in which there is an urgent need for the rapid development of health care services for older people with chronic and disabling diseases and disorders. The country therefore faces two related problems: which services are most needed and will be most effective, and what needs to be done to implement these services?

Neither the doctoral evaluation of the Barnsley RRS nor the national evaluations of intermediate care services have been able to produce definitive evaluations of the outcomes and effectiveness of these new services. On the other hand, the Barnsley evaluation produced important lessons about the challenges, tasks and problems that a service innovation creates. While some are context and system-specific, it appears that many are generalisable and transferable. Two examples of serious problems with the smooth working of the RRS innovation in its early months are instructive. One was the less than complete understanding of the precise role of the RRS team on the part of other health and social care professionals (as well as the patients and the general public). This was a failure of information diffusion, education, publicity and preparation. Such failures are likely to be associated with many service innovations, partly because the problems are not easy to overcome. The general lesson, for South Korea as well as Britain, is that the issue of information dissemination must be more vigorously addressed, and that no service innovation is introduced without careful assessment of the 'system impacts'.

The other strong lesson from Barnsley is that there was insufficient resource for staff re-training, not only before the launch, but also for staff who joined the service after its inauguration (to replace those who resigned or were redeployed). Shortages of trained and qualified staff meant that at times the RRS could not deliver the services it was set up to provide. This is likely to be another general problem of service innovations, particularly when they are entirely new. This is because it is very difficult in advance to anticipate the level and types of training needs. One impact causes particular problems: the staff who receive additional training to provide a new service (including supervisory or decision-making skills) are able to apply for more responsible and better paid positions. The rate of resignations by staff who were appointed to other posts increased, raising the continuing need for training.

In the next section, other specific lessons from the early implementation of the Barnsley RRS are discussed in relation to wider issues about the transfer of health care and health service models. In the UK in recent years, there has been increasing interest in 'health care technology transfer', that is the adoption of health care service models developed in other countries. This has been led by the Department of Health, which has introduced a succession of models from the United States. A recent example is the *Evercare* model of nurse-practitioners who carry out comprehensive assessments of the therapies and treatments given to older people with multiple chronic conditions (Kane and Huck, 2000). While however there has been considerable research on the transfer of specific health-care therapies, there is as yet little on the transfer of service models. The following account summarises the main lessons that have been identified in the limited literature.

Care models transfer

Among both the long-established and the newly affluent countries of the world, health services are very heterogeneous in their size, organization, resources, production, and population coverage, both between and within countries. The characteristics of an individual country's health services are determined by many factors such as: national overall socio-economic development, the current political and economic systems, and the legal and normative framework of the health care system. All these affect the structure of service provision by type and mix of ownership of facilities and type of payment system (public, private or a mixture), the financing framework and the mode of reimbursement for services provided, the administrative and clinical organization of health services, their geographical distribution, and historical trends in healthcare utilization (Pan American Health Organization, 1999). The key political, managerial, technical and structural backgrounds vary enormously from one country to another

The complexity and diversity of most countries' health care systems means that few nations can be characterized by a single "model". In this situation, the transfer of a new care model from one country to another faces tremendous obstacles. Any attempt to introduce a new service model, such as intermediate care, is made difficult because the supporting services and staff profiles and professional practices are not the same. Often there is insufficient technical training, and limited financial and human resources. In addition, the transfer may be problematic if the level of socio-economic development is markedly different. Very often, however, modernizing politicians and the professions' leaders are encouraged by advisers. Furthermore, international agencies and commercial consultanciesoffer technical assistance to introduce or sustain a health technology or service model that may be barely or not at all feasible or appropriate in the receiving country (Tjam, 1994).

When service innovations are introduced by central government, they usually have targeted objectives but rarely is there sufficient funding for staff training. Often only a simplified version of the innovation is introduced, and the impact of the project on the local health system is often disruptive. This may lead to abandonment of the innovation at an early implementation stage, with potentially unfortunate results in the mid and long-term. The compatability of the innovation with existing services and the integrity of the total system should be given far more attention before new models of care are adopted.

Political considerations have enormous influence on the international diffusion and adoption of health care technologies. The political environment generally restricts the decentralization of decision-making. Without doubt, the most serious mistake any reformer can make is to assume the transfer to be a managerial exercise devoid of political causes and objectives (Omar, 2002). Moreover, most innovative care services require an increased input of trained and skilled labour besides special equipment and supplies. But additional staff training is not easily achieved in the short term, and too often is disregarded at the planning stage. Very often, the lack of staff training seriously hinders the implementation of the new service.

When assessing the likely benefits, costs and impacts of a health care or health service technology transfer, these obstacles should be borne in mind. It is particularly important to learn from the experience of other countries and to formulate systematic implementation strategies for health sector reforms, rather than to import uncritically structural models developed in a single foreign country. Key factors in the care model transfer process should be considered. In addition to technical issues, successfully implementing a new care model depends on (long-term) financial support, political co-operation, an appropriate functional infrastructure, good inter-service and inter-professional communication, and an understanding of both socio-cultural and environmental contexts and impacts. Though likely to be beyond the direct control of the reformers and service providers, these factors can be described and assessed by well designed research (Harris and Tanner, 2000).

For any new care service to be compatible with and to integrate with the existing system, it is stressed that a key criteria of acceptability is that it meets the patients' or recipients' health-care needs as well as the operational requirements and feasibility of the health-care system. Whereas the preliminary transfer of knowledge is often fast, partly through intensive training workshops for a few demonstration projects, the wider implementation and adoption is gradual and requires continued, long-term follow-up. Suitable follow through requires long-term resources to make available systematic advice and consultation, technical supervision, and training and practice manuals. Poor follow-up support is the reason why many efforts to transfer innovative care models fail (Harris and Tanner, 2000). Overall, long-term follow up in the form of technical, financial, and material support is essential.

If the transfer of a new care model is to succeed, the following conditions and criteria should be considered. The objectives must be consistent with the existing cultural and socio-economic conditions. Besides, they should provide acceptable outcomes at an affordable cost for the service recipients. Therefore, the assessment of unmet needs and of the limitations of existing care services, and the appraisal of the care needs of the population are major conditions for the proper transfer of a new care model. The mode of delivery and the care practice must be adapted to the country or region and regularly reviewed. A standing body should be charged with the testing and reviewing of (new) care models for their appropriateness to the country or region. Continued partnership with the 'donor' care service or country is a prerequisite for the sustainable transfer of a care model from one country to another.

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Appendices

Appendix 1: Refined 'Client Satisfaction Questionnaire' (CSQ)

Please help us improve the.service by answering some questions about the treatment and care you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Please, circle your answer

1. How would you rate the treatment and care you have received?

Excellent	Good	Fair	Poor

2. Did you receive the kind of treatment and care you wanted?

Not at all,	Mostly not,	Yes, mostly	Yes, entirely

3. To what extent has our treatment and care met your needs?

Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our treatment and care to him or her?

No, definitely not	No, mainly	Yes, generally	Yes, definitely

5. How satisfied are you with the amount of treatment and care you have received?

Dissatisfied	Indifferent or mildly dissatisfied	Mostly Satisfied	Very Satisfied

6. Have the treatment and care you received helped you to deal more effectively with your problems?

Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense how satisfied are you with the treatment and care you have received?

Very Satisfied	Mostly Satisfied	Indifferent or mildly dissatisfied	Dissatisfied

8. If you were to seek help again, would you come back to our treatment and care?

No, Definitely	No, I don't think so	Yes, I think so	Yes, Definitely

If you wish to add any more comments about the treatment and care you received, please use this space:

....

....

....

....

....

....

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire to: Kyeung Mi Oh

SISA, Community Sciences Centre
Northern General Hospital
Sheffield S5 7AU

Appendix 2: Final questionnaire 1 for RRS evaluation study

CONFIDENTIAL

☐☐☐☐

BARNSLEY RAPID RESPONSE TEAM SERVICE

PATIENTS VIEWS

Questionnaire

Your views about the care or treatment for an acute illness, which is just coming to an end, would be of great interest and value to this study. Please complete the questions as best you can.

The information is collected exclusively for academic research. Your replies will be entered anonymously into a table and only aggregate results will be released: no individual responses will be passed to any individual or body. Your answers will be treated as strictly confidential: no reference to identifiable individuals will be made except with their specific permission.

Please complete the questionnaire yourself and as best you can, stating your own circumstances and giving your own opinion.

Questionnaire instruments utilised:
The Barthel ADL index
Philadelphia Geriatric Centre Morale Scale
Instrumental Activities of Daily Living (IADL) Scale

This study has been organised by the University of Sheffield, Sheffield Institute for Studies on Ageing.

Enquiries about this project may be directed to Kyeung Mi Oh,
SISA, Community Sciences Centre,
Northern General Hospital,
Sheffield, S11 7AU
(Tel: 0114 271 5924)

The questionnaire begins with a few personal questions about you and your home. These are to enable me to compare different groups of people. As made clear on the front sheet, none of this personal information will be released to anyone else.

ABOUT YOU

1. What is your name? ....

2. Are you male or female? (Please, tick box)
   Male ☐

   Female ☐

3. What is your date of birth (day/month/year)? (/ /)

4. Which country were you born in?..

5. How do you describe your ethnic group membership? ....

6. Please indicate in what kind of home you live.

   My own home (house, flat, etc) ☐

   A relative's home, (*e.g.* daughter's, son's, friend's) ☐

   A residential care home ☐

   A nursing home ☐

   Other (Please describe)..

7. If you live in an ordinary home (not a residential care or nursing home), please indicate how many people and who you live with

I live alone ☐

I live only with my spouse or partner ☐

I live only with only one other person, not a spouse or partner,

such as a parent, child, brother, sister or cousin ☐

I live with two or more other people ☐

8. Do you have a carer at home?

Yes, a paid carer ☐

Yes, a relative, neighbour, or other unpaid carer ☐

Yes, both (a paid carer and an unpaid carer) ☐

No ☐

If yes, please write down who they are
(job title or relation as appropriate)......................................

9. Before you were ill, did you receive any health or social services of the following

Home care ☐

Day care at a day centre ☐

Respite care as with a temporary stay in a nursing home or resource centre ☐

Night Sitters ☐

Neighbourhood support service ☐

Home help ☐

Meals delivery service to your home ☐

Home Loans ☐

Alarm systems installed in you home ☐

Aids and adaptations ☐

Transport service ☐

Community (District) nurse service ☐

Health visitor ☐

Physiotherapy in your home ☐

Chiropodist ☐

Others (please, write in)..

This study is evaluating how well different forms of treatment in Barnsley turn out for the patients. To do this, I have to collect some details about your physical well-being and functioning. Patients in very different circumstances will be included, from the generally quite healthy to those with many long-standing problems. I therefore have to ask about some rare possibilities. Please complete as many of the questions as you can.

Barthel ADL Index

Please tick the appropriate boxes.

Dressing

Independent (including buttons, zips, laces) ☐

Needs help, but can do about half unaided ☐

Dependent ☐

Mobility

Independent (but may use any aid, *e.g.* stick) ☐

Walks with help of one person (verbal or physical) ☐

Wheel-independent including corners, etc ☐

☐

Immobile

Stairs, as in house

Independent up and down ☐

Needs help (verbal, physical, carrying aid) ☐

Unable ☐

Bathing (Baths or showers)

Independent ☐

Dependent ☐

Bowels

Continent ☐

Occasional accident ☐

Incontinent (or needs to be given enema) ☐

Bladder

Continent (for over 7 days) ☐

Occasional accident (Max, once per 24 hours) ☐

Incontinent, or catheterized and unable to manage ☐

Grooming

Independent face / hair / teeth / shaving (implements provided) ☐

Needs help with personal care ☐

Toilet use

Independent ☐

Needs some help, but can do alone ☐

Dependent ☐

Feeding

Independent (food provided in reach) ☐

Needs help cutting, spreading butter, etc ☐

Unable ☐

Transfer

Independent (but may use any aid, *e.g.* stick) ☐

Walks with help of one person (verbal or physical) ☐

Wheelchair independent including corners, etc ☐

Unable – no sitting balance ☐

Instrumental Activities of Daily Living (IADL) Scale

Please circle the response that most applies for each activity

Using the telephone

Needs no help	Needs some help	Unable to do at all

Getting to places beyond walking distance

Needs no help	Needs some help	Unable to do at all

Grocery shopping

Needs no help	Needs some help	Unable to do at all

Preparing meals

Needs no help	Needs some help	Unable to do at all

Doing housework or handyman work

Needs no help	Needs some help	Unable to do at all

Doing laundry

Needs no help	Needs some help	Unable to do at all

Taking medications

Needs no help	Needs some help	Unable to do at all

Managing money

Needs no help	Needs some help	Unable to do at all

I would also like to ask about your morale after your illness and now that the recent phase of your treatment and care is coming to an end. I am using a set of question that was developed some years ago and when we count up the answers, which produces very useful information. There are 17 items – please answer all the questions if you possible can.

Philadelphia Geriatric Center Moral Scale

Please circle the response that most closely matches your condition.

1. Do things keep getting worse as you get older? **Yes** **No**
2. Do you have as much energy as you did last year? **Yes** **No**
3. Do you feel lonely much? **Yes** **No**
4. Do you see enough of your friends or relatives? **Yes** **No**
5. Do little things bother you more this year? **Yes** **No**
6. As you get older do you feel less useful? **Yes** **No**
7. Do you sometimes worry so much you can't sleep? **Yes** **No**
8. As you get older are things better than expected? **Yes** **No**
9. Do you sometimes feel that life isn't worth living? **Yes** **No**
10. Are you as happy now as you were when you were younger? **Yes** **No**
11. Do you have a lot to be sad about? **Yes** **No**
12. Are you afraid of a lot of things? **Yes** **No**

13. Do you get angry more than you used to? **Yes** **No**

14. Is life hard for you most of the time? **Yes** **No**

15. Are you satisfied with your life today? **Yes** **No**

16. Do you take things hard? **Yes** **No**

17. Do you get upset easily? **Yes** **No**

Please help us improve the service by answering some questions about the treatment and care you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

Here is a list of 9 features of care.

(a) Adequate medical treatment or care for illness

(b) Kind and courteous staff attitude

(c) Comfortable, clean, and quiet environment for your recovery

(d) Quality of food

(e) Near to your home or your family

(f) Convenient and comfortable facilities (*e.g.* telephone use, bath, toilet etc)

(g) Respecting privacy

(h) Sufficient information about the services that will support after discharge (*e.g.* social care, district nurse, or physiotherapy etc)

(i) Clear communication of information about the condition and about the appropriate treatment

We would like to know how happy you were with above.

1. Which of the features (a) to (i) above, were you most satisfied with? (Please, write the letters in the boxes)

First	Second	Third
☐	☐	☐

2. Which of the features (a) to (i) above, would you most like to see improved?

First	Second	Third
☐	☐	☐

3. Is there anything not mentioned on the list that you were very satisfied with?

....

4. Is there anything not mentioned on the list that you were very dissatisfied with?

....

If you wish to add any more comments about the treatment and care you received, please use this space:

....

....

....

....

....

....

....

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire to: Kyeung Mi Oh
SISA, Community Sciences Centre, Northern General Hospital
Sheffield S5 7AU

Appendix 3: Questionnaire 2

CONFIDENTIAL

Evaluation of Barnsley Health and Social Services for Older People with Acute Illness

Questionnaire

**3 months after the care or treatment for an acute illness,
your well-being would be of great interest and value
to this study.
Please complete the questions as best you can.**

**This study has been organised by the University of Sheffield,
Sheffield Institute for Studies on Ageing.**

**Enquiries about this project may be directed to
Kyeung Mi Oh,**

**SISA, Community Sciences Centre,
Northern General Hospital,
Sheffield, S5 7AU
(Tel: 0114 271 5924)**

1. Please indicate in what kind of home you live.

My own home (house, flat, etc) ☐

A relative's home, (*e.g.* daughter's, son's, friend's) ☐

A residential care home ☐

A nursing home ☐

Other (Please describe)......................... ....

2. If you live in an ordinary home (not a residential care or nursing home), please indicate how many people and who you live with

I live alone ☐

I live only with my spouse or partner ☐

I live only with only one other person, not a spouse or partner, such as a parent, child, brother, sister or cousin ☐

I live with two or more other people ☐

3. Do you have a carer at home?

Yes, a paid carer ☐

Yes, a relative, neighbour, or other unpaid carer ☐

Yes, both (a paid carer and an unpaid carer) ☐

No ☐

If yes, please write down who they are (job title or relation as appropriate)..........................

4. **After you were discharged from rapid response service scheme, did you receive any health or social services of the following**

Home care ☐
Day care at a day centre ☐
Respite care as with a temporary stay in a nursing home
or resource centre ☐
Night Sitters ☐
Neighbourhood support service ☐
Home help ☐
Meals delivery service to your home ☐
Home Loans (eg. a wheelchair, commode chair, walking
frame, or raised toilet seat hoist) ☐
Alarm systems installed in you home ☐
Aids and adaptations ☐
Transport service ☐
Community (District) nurse service ☐
Health visitor ☐
Physiotherapy in your home ☐
Chiropodist ☐
Others (please, write in)..

5. After discharge from rapid response service scheme about three months age, ***(Please circle your answer)***

I have been admitted to hospital.	Yes / No
I have had a fall.	Yes / No
I have been admitted to residential or care home.	Yes / No

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire to:
Kyeung Mi Oh

SISA, Community Sciences Centre
Northern General Hospital

Appendix 4: Patient information sheet and consent form

The University of Sheffield

Sheffield Institute for Studies on Ageing

Kyeung Mi Oh
Community Sciences Centre
Northern General Hospital
Sheffield S5 7AU
Telephone: 0114 271 5924
Email: mdp99kmo@sheffield.ac.uk

Patient Information Sheet

1. **Study title**
   Evaluation of the Barnsley health and social services for older people with acute Illness. Part 1: Individual patient outcomes
2. **What is the purpose of the study?**
   The purpose of this study is to evaluate the home-based services provided by the rapid response team and hospital-based services dedicated to older people with acute illness. We wish to recommend the development of services for older people following this study.
3. **Why have I been chosen?**
   You are invited because you are aged over 65 years and using the rapid response team service or the hospital-based care services for treatment and care to recover from acute illness.
4. **Do I have to take part?**
   It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. This will not affect the standard of care you receive.
5. **What will happen to me if I take part?**
   If you take part, you will be given a questionnaire that contains some questions to assess your satisfaction with your treatment and care, health outcomes, service outcomes and your opinion of the strengths and limitations of the treatment and its mode that you received.
6. **What are the possible disadvantages and risks of taking part?**
   There are no disadvantages and risks of taking part. Your care will not be affected in any way.
7. **Will my taking part in this study be kept confidential?**
   All information that is collected about you during the course of the research will be kept strictly confidential.
8. **What will happen to the results of the research study?**
   At the end of the research, results will be analysed by the researcher and results will be written up for publication. All results will be identified using a number and your name and personal details will not be traceable by anyone not involved in the study. You may be informed of the results of this study, if desired.
9. **Who is organising and funding the research?**
   This research is being organised by the University of Sheffield, Sheffield Institute for Studies on Ageing, which is part of the Department of Medicine.

10. **Who is reviewed the study?**
The Barnsley District General Hospital's Research Ethics Committee has reviewed this study proposal to ensure compliance with pre-set ethical standards.

11. **Contact for further information:**
If, at any point in the study, you wish to obtain further information or discuss any part of the study, please contact the researcher, **Kyeung Mi Oh** (See phone number above) who will answer you questions concerning the study. You may of course, contact Professor **Tony Warnes**.

You will be given a copy of this Patient Information Sheet and of the signed consent form.

CONSENT FORM

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐

4. I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 5: Local Ethics committee approval

Barnsley
Health
Authority

Hillder House
49/51 Gawber Road
Barnsley, S75 2PY.
Telephone: Barnsley (01226) 779922
Fax: (01226) 730054
DX 709301 Barnsley 5

Chairman: Pauline Acklam M.B.E. M.I.Mgt. Chief Executive: Ailsa Claire B.A. M.A.

NHS

Your Ref: Our Ref: AJT/CT Please ask for: MR A J THORPE
DDI: 01226 777034

BARNSLEY RESEARCH ETHICS COMMITTEE

08 March 2001

Kyeung Mi Oh
Sheffield Institute for Studies on Ageing
Community Health Science Centre
Northern General Hospital
Sheffield
S5 7AU

Dear Kyeung

EVALUATION OF THE BARNSLEY RAPID RESPONSE TEAM FOR OLDER PEOPLE WITH ACUTE ILLNESS

Thank you for attending the Barnsley Research Ethics Committee meeting on 7 March 2001 to discuss your application in connection with the above proposed study. The Committee has agreed to approve the application but in communicating this decision I have been asked to emphasise that members have reservations about the potential for bias in the analysis of your research data as a result of difficulties in matching the two patient samples in relation to their primary clinical conditions. The Committee would urge that you attempt to achieve the closest possible match of clinical factors as between the two groups of patients.

You should also ensure that paragraph 4 of the patient information sheet is amended to remove the typographical error.

Would you please note that in the event of any unforeseen changes or new information which would raise questions about the continued conduct of the research this must be notified to the Committee immediately. The Committee would also wish to be provided with an end of study report of the trial in due course.

Yours sincerely

Father P Yates
Vice Chairman

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Appendix 6: Evaluation questionnaires to staff

CONFIDENTIAL

☐☐☐☐

Barnsley Rapid Response Service

Evaluation Study

Evaluation Questionnaire to General practitioners

Your informed views about the strengths and limitations of the new rapid response team service for older people with acute illness in Barnsley would be of great interest and value to this study. Please complete the questions as best you can.

The information is collected exclusively for academic research. Your replies will be entered anonymously into a table and only aggregate results released: no individual responses will be passed to any individual or body. Your answers will be treated as strictly confidential: no reference to identifiable individuals will be made except with their specific permission.

Please complete the questionnaire yourself, stating your own circumstances and giving your own opinion.

This study has been organised by Kyeung Mi Oh of the University of Sheffield, Sheffield Institute for Studies on Ageing, to whom enquiries may be directed at SISA, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU
(Tel: 0114 271 5924)

ABOUT YOU

May I first collect your basic personal details for record purposes.

Name: ....

Job title: ....

Place of work: ....

Employer (or practice): ....

Office address:..

....

....

Telephone number: .... **email:** ....

---

1. How did you become aware of the RRS?

Letter from..

Or, Telephone call from..

Or, Word of mouth..

2. When did you first learn about RRS?

Month ( ) Year ( )

3. What criteria do you apply when referring a patient to RRS (Rapid Response Service)? Please, tick the boxes below that are relevant.

Patient's age ☐

The availability of an informal carer ☐

Cognitive ability ☐

Patient's or family's agreement ☐

Medical condition ☐

Patient's home address ☐

Patient's functional ability ☐

The capacity of RRT ☐

Others (Please describe) ....

....

....

....

....

....

....

For the following next questions, please tick the box .

4. Before you refer a patient to BDGH (Barnsley District General Hospital) or RRS, do you discuss the step with the patient?

Yes, always ☐ Yes, sometimes ☐ Never ☐

5. Has any patient (or a relative of a patient) who had used RRS before or knows the service asked you to refer a patient to RRS(Rapid Response Service) like respite care?

Yes ☐ No ☐

6. When a patient is referred to the RRS and RRT asked you to accept the medical responsibility, do you ....?

always agree ☐ agree in some cases ☐ decline ☐

7. Have you found that some patients with many social problems or long-term medical problems (not acutely ill enough to admit to a hospital) were referred to RRS to use the RRS like social service?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

8. Among the patients that you have been asked by the RRS team to take medical responsibility for, please indicate the approximate proportion about whom you have had ....

Seriously worries	10% ☐	25% ☐	50% ☐	75% ☐	100% ☐
Some worries	10% ☐	25% ☐	50% ☐	75% ☐	100% ☐
No concern	10% ☐	25% ☐	50% ☐	75% ☐	100% ☐

For the following questions, please tick the box that most closely expresses your opinion.

9. An RRS patient increases my workload...

Not at all	Slightly	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

10. The RRS team forms an inappropriate barrier between me and the patient.

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
☐	☐	☐	☐	☐

11. Please indicate your level of agreement with the assertion that taking on the medical responsibility in insufficiently remunerated.

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
☐	☐	☐	☐	☐

12. RRS enables older people to stay at home and remain independent for as long as possible.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

13. RRS reduces the number of emergency admissions/ re-admissions to hospital and nursing / residential care homes.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

14. RRS enables a more comprehensive assessment of risk and the social and health care needs of older people than ordinary hospital care.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

15. RRS is just a 'new idea' that serves the political purposes of the current Government and is not well designed to meet the needs of older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

16. I have found the difficulties with caring and referring older patients with acute illness due to the rapid change in the care services for older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
☐	☐	☐	☐	☐

17. RRS is a practical alternative to acute hospital service for older people with acute illness.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

18. Please specify up to three health problems of older people to which RRS can appropriately respond:

1. ....

....

2. ....

....

3. ....

....

19. Please list up to three advantages or positive features of the RRS.

1. ....

....

2. ....

....

3. ....

20. Please list up to three disadvantages or problems of the RRS.

1. ....

....

2. ....

....

3. ....

....

21. If you wish to add more comments about comparable or alternative service developments that you would strongly recommend, please use this space:

....

....

....

....

....

....

....

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire
in the enclosed stamped and addressed envelope.
To: Kyeung Mi Oh,
SISA (Sheffield Institute for Studies on Ageing),
Community Sciences Centre, Northern General Hospital,
Sheffield S5 7AU

CONFIDENTIAL

☐☐☐☐

Barnsley Rapid Response Service

Evaluation Study

Evaluation Questionnaire to Rapid Response Team

Your informed views about the strengths and limitations of the new rapid response team service for older people with acute illness in Barnsley would be of great interest and value to this study. Please complete the questions as best you can.

The information is collected exclusively for academic research. Your replies will be entered anonymously into a table and only aggregate results released: no individual responses will be passed to any individual or body. Your answers will be treated as strictly confidential: no reference to identifiable individuals will be made except with their specific permission.

Please complete the questionnaire yourself, stating your own circumstances and giving your own opinion.

This study has been organised by Kyeung Mi Oh of the University of Sheffield, Sheffield Institute for Studies on Ageing, to whom enquiries may be directed at SISA, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU (Tel: 0114 271 5924)

ABOUT YOU

May I first collect your basic personal details for record purposes.

Your name: ....

Job title: ....

For the following questions, please tick the box, which most closely expresses your opinion:

1. RRS enables older people to stay at home and remain independent for as long as possible.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

2. RRS reduces the number of emergency admissions/ re-admissions to hospital and nursing / residential care homes.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

3. RRS enables a more comprehensive assessment of risk and the social and health care needs of older people than ordinary hospital care.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

4. RRS patients are more likely to receive community health services (physiotherapy, occupational therapy, district nursing service, chiropodist etc) than hospital patients after discharge.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

5. RRS patients are more likely to receive social services (home care, respite care, day care, home help etc) than hospital patients after discharge.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

6. RRS is just a 'new idea' that serves the political purposes of the current Government and is not well designed to meet the needs of older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

7. I found the difficulties with caring and referring the older patients with acute illness due to the rapid change in the care services for older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

8. I found that the RRS patients need more intensive occupational therapy.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

9. I found that the RRS patients need more intensive physiotherapy.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

10. When you take care of the patient, have you met an ethical problem related to where is the best place to take care of older people?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

11. When you take care of the patient, have you faced an ethical problem as to whether the change in the care services for older people is for the quality of life for older people, or for the benefit of the government?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

12. When you take care of the patient, have you been worried about the patient's safety due to the different care circumstances from the hospital?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

13. When you take care of the patient, have you been worried about your own safety related to misleading professional conduct due to not settled criteria or guideline for your work?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

14. When you take care of the patient, have you been worried about legal problem due to not settled criteria or guideline for your work?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

....

....

15. The criteria for the eligible RRS patient is well enough developed to make a decision confidently to accept a patient to RRS.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

16. The criteria for the decision to place the RRS patient at home with a carer, resource centre or nursing home have been sufficiently developed.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

17. Have you experienced a problem working with GP when you asked the GP for the consent for the medical responsibility of the RRS patient?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

18. Have you experienced difficulties with working with the GP when you want to discuss about the accepted RRS patient's changed medical condition or necessary treatment with the GP?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

19. RRS is a practical alternative to acute hospital service for older people with acute illness.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

20. Have you found that some patients with many social problems or long-term medical problems (not acutely ill enough to admit to a hospital) were referred to RRS to use the RRS like social service?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

21. Have you experienced difficulties during working in a new service?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

....

22. Have you experienced difficulties with working with social workers?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

....

23. Have you experienced difficulties with working with staff in A&E or admission ward in the BDGH?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

....

24. Have you experienced the problem with communication between staff?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If yes, please, list the examples..

....

....

....

25. Have your opinions for the development of RRS or to solve some problems of RRS been well considered in the higher grade of the staff?

Yes, often	Yes, sometimes	Not often	Very seldom	Never
☐	☐	☐	☐	☐

If 'no', please, list the examples..

....

....

....

26. Please specify up to three health problems of older people to which RRS can appropriately respond:

1. ....

....

2. ....

....

3. ....

27. Please list up to three advantages or positive features of the RRS:

1. ....

....

2. ....

....

3. ....

28. Please list up to three disadvantages or problems of the RRS:

1. ....

....

2. ....

....

3. ....

29. If you wish to add more comments about comparable or alternative service developments that you would strongly recommend, please use this space:

....

....

....

....

....

Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire
in the enclosed stamped and addressed envelope.
To: Kyeung Mi Oh,
SISA (Sheffield Institute for Studies on Ageing),
Community Sciences Centre, Northern General Hospital,
Sheffield S5 7AU

CONFIDENTIAL

☐☐☐☐

Barnsley Rapid Response Service

Evaluation Study

Staff Evaluation Questionnaire

Your informed views about the strengths and limitations of the new rapid response team service for older people with acute illness in Barnsley would be of great interest and value to this study. Please complete the questions as best you can.

The information is collected exclusively for academic research. Your replies will be entered anonymously into a table and only aggregate results released: no individual responses will be passed to any individual or body. Your answers will be treated as strictly confidential: no reference to identifiable individuals will be made except with their specific permission.

Please complete the questionnaire yourself, stating your own circumstances and giving your own opinion.

This study has been organised by Kyeung Mi Oh of the University of Sheffield, Sheffield Institute for Studies on Ageing, to whom enquiries may be directed at SISA, Community Sciences Centre, Northern General Hospital, Sheffield S5 7AU (Tel: 0114 271 5924)

ABOUT YOU

May I first collect your basic personal details for record purposes.

Your name: ....

Job title: ....

Place of work: ....

Office address:..

....

....

Telephone number: .... **email:** ....

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1. How did you become aware of the RRS?

    Letter from...

    Or, Telephone call from...

    Or, Word of mouth...

2. When did you first learn about RRS?

    Month (   )   Year (   )

For the following questions, please tick the box, which most closely expresses your opinion:

3. RRS enables older people to stay at home and remain independent for as long as possible.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

4. RRS reduces the number of emergency admissions/ re-admissions to hospital and nursing / residential care homes.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

RRS is a practical alternative to acute hospital service for older people with acute illness.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

Have you found that some patients with many social problems or long-term medical problems (not acutely ill enough to admit to a hospital) were referred to RRS to use the RRS like social service?

Yes, often	Yes, sometimes	Not often	Very seldom	Never	I don't know
☐	☐	☐	☐	☐	☐

RRS enables a more comprehensive assessment of risk and the social and health care needs of older people than ordinary hospital care.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

RRS patients are more likely to receive community health services (physiotherapy, occupational therapy, district nursing service, chiropodist etc) than hospital patients after discharge.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

RRS patients are more likely to receive social services after discharge (home care, respite care, day care, home help etc) than hospital patients.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

RRS is just a 'new idea' that serves the political purposes of the current Government and is not well designed to meet the needs of older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

I am finding increasing difficulties with caring for and onward referral of older patients with acute illness because of the rapid changes in care services for older people.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

I have found that the RRS patients need more intensive occupational therapy.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

I have found that the RRS patients need more intensive physiotherapy.

Strongly Agree	Agree	Neutral	Disagree	Strongly disagree	I don't know
☐	☐	☐	☐	☐	☐

Please specify up to three health problems of older people to which RRS can appropriately respond:

1. ....
....
2. ....
....
3. ....

Please list up to three advantages or positive features of the RRS:

1. ....
....
2. ....
....
3..
....

Please list up to three disadvantages or problems of the RRS:

1. ....
....
2. ....
....
3..
....

Please use the space below to note the kinds of problems that you have experienced in working with RRST (Rapid Response Service Team)?

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If you wish to add more comments about comparable or alternative service developments that you would strongly recommend, please use this space:

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Many thanks for all your time and patience. The information you have given will be of great help, indeed your co-operation is vital to the study's success.

Please return the completed questionnaire
in the enclosed stamped and addressed envelope.
To: Kyeung Mi Oh,
SISA (Sheffield Institute for Studies on Ageing),
Community Sciences Centre, Northern General Hospital,
Sheffield S5 7AU

Appendix 7: Participant information letters

Letter to RRS team and other collaborative care professionals

The University of Sheffield

Sheffield Institute for Studies on Ageing

Kyeung Mi Oh
Community Sciences Centre
Northern General Hospital
Sheffield S5 7AU
Telephone: 0114 271 5924
Email: mdp99kmo@sheffield.ac.uk

Dear

We are writing to you ask for help with an evaluation of the Rapid Response Service which is approved and supported by the Barnsley Health Authority and Elderly Services Board. You have been chosen because you are involved in the care of the Barnsley Community Health Care NHS Trust, Rapid Response Service Patients.

We would now like to collect your views about the strengths and limitations of the new RRS for older people through the enclosed short questionnaire. Your replies will be entered anonymously into a database and only aggregate results released: no individual responses will be passed to any individual. Your answers will be treated as strictly confidential. The questionnaire probably takes no more than twenty minutes to complete. We would be very grateful if you could complete this and return it in the enclosed free post envelope.

Thank you in advance for your help. The information that you and others have provided is helping me to learn a great deal about care services for older people and will be of value to the Trust. All this help greatly appreciated.

Yours sincerely

Tony Warnes

Kyeung Mi Oh

Letter to General practitioners

The University of Sheffield

Sheffield Institute for Studies on Ageing

Kyeung Mi Oh
Community Sciences Centre
Northern General Hospital
Sheffield S5 7AU
Telephone: 0114 271 5924
Email: mdp99kmo@sheffield.ac.uk

Dear

We are writing to ask for your help with the research. The purpose of the research is to evaluate the home-based service (RRS) provided by rapid response team dedicated to older people with acute illness.

You have been chosen because you have been refer a patient to RRS or a RRS patient have been referred to you and took the medical responsibility for the patient.

We would now like to establish and analyse staff' opinion who are involved in RRS about the strengths, weaknesses and optimal development of the services. We wish to recommend the further developed services for older people via this research. In order to ask your opinion, a semi-structured questionnaire has been designed. It will not probably take no more thank 15 minutes to complete the questionnaire. We would be very grateful if you could complete this (and return it in the enclosed stamped addressed envelope).

Thank you in advance for your help. The information that you and others have provided is helping us to learn a great deal about care services for older people. All this helps greatly appreciated.

Yours sincerely

Tony Warnes

Kyeung Mi Oh