Improving care of older people through intermediate services

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The aim of intermediate care, according to the National Service Framework for Older People, is to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge, and maximise independent living. In Hackney, east London, this has resulted in two innovative approaches to meeting the NSF target. Homerton University Hospital NHS Foundation Trust has developed one post that addresses the needs of informal carers, and another that ensures older people who need help with their finances are able to access expert advice and support.

Intermediate care is seen as the core element in the government’s programme for improving services for older people. It earned a standard all of its own in the National Service Framework for Older People (Department of Health, 2001a). A health service circular (DoH, 2001b) defined intermediate care as a range of services targeted at people who, for example, would otherwise face unnecessarily prolonged hospital stays, inappropriate admission to acute inpatient care, long-term residential care, or continuing NHS inpatient care (Box 1).

Intermediate care should be an integral part of a seamless continuum of services linking health promotion, preventive services, primary and secondary care, acute hospital care, community health services, social services, and support for carers.

Intermediate care is not just about older people (a 50-year-old patient with multiple sclerosis might need short-term help but not an acute bed, for example) although the majority of patients are over the age of 65. Across Hackney in east London, primary care, secondary care, and social services staff met in a planning group to design a unified system for intermediate care. Homerton University Hospital developed two new services as part of that system: a carers’ specialist, and a benefits advisory service.

The carers’ specialist

It was agreed that meeting the needs of informal carers was a crucial factor in the care of older people. There was evidence that discharges often hinged on the involvement of carers, and that some professionals assumed family members were able or willing to take on the role without assessing whether they needed support. Equally, it was clear that some admissions could be avoided if carers had another source of support and advice.

Within the planning group, we explored how vital carers were to a patient’s care journey, and subsequently made a bid for funding to create a full-time carers’ specialist post. This was successful and the post was filled in November 2000 by a staff member who had a nursing background but who had more recently worked providing follow-up support to patients after discharge from the stroke unit. She had also cared for her mother through Alzheimer’s disease. Her objective was to transfer her experience and knowledge into a carer-centred service.

In the first 12 months there were 332 referrals to the specialist, primarily from the older people’s rehabilitation services and the stroke unit. There were also a considerable number of referrals from the nurse-led unit, outpatients, and the day hospital. The main interventions were family support and advice, discharge follow-up, setting up specific services, such as befriending services and bereavement support, and organising respite programmes. The service has gone from strength to strength, and a new joint health and social care assistant role has now been funded to carry out carer assessments and enable the carers’ specialist to concentrate on needs arising from the assessments.

The benefits adviser

Hackney is one of London’s most socially and economically deprived inner-city communities. The housing stock is of poor quality, and many older people are surviving
on meagre state pensions and living on the poverty line. At the Homerton, we recognised that low income, housing problems, misunderstandings about benefits, and inability to complete applications can directly affect a person’s health, well-being and ability to cope at home.

To address this, the trust bid for and received £20,000 to contract an independent service, the Benefits Advisory Service, to help older people overcome these difficulties. The benefits adviser had previously worked extensively in the income maximisation field for the local council but, when her department was closed, moved to the independent sector and started her own business.

In 2003, the benefits adviser helped patients claim about £130,000, of which £30,000 comprised backdated benefits and one-off payments for 90 patients and carers. This brings the total claimed since the service started in June 2001 to £635,000. It includes unclaimed benefits to which people did not realise they were entitled, and benefits that had been wrongly assessed and so were increased.

**Launching the new services**

Working with the multi-agency team, staff at Homerton University Hospital investigated how and where these services should focus their work. It was anticipated that they could become extremely popular, so clear criteria and objectives were set (Boxes 2–3) to ensure they served the neediest people.

Both services were launched across the trust with a briefing and information about what the services would provide and how to refer patients. Presentations were made to key forums such as charge nurse meetings and therapy service meetings. Information was also included in departmental newsletters.

The initial difficulties and challenges were ones we had anticipated. We knew that many general staff were quite ‘unidisciplinary’ in their approach and only considered the patient from the perspective of their chosen specialism. The needs of the patient’s carers were not something they would normally consider, and having a service to cater for this would not necessarily change their views.

We engaged the discharge team, ward sisters and charge nurses, and used well-established multidisciplinary models from older people’s care and rehabilitation to inform other staff across the trust. It was not easy – many people came to our attention whose needs had not been fully considered, and often it was the carers’ specialist herself who identified someone on the wards whom she could help.

With the Benefits Advisory Service, the biggest problem was that too many patients wanted help. We had to prioritise as our funding was limited. This is still the case and, as funds are tight, it does not look likely to change in the immediate future.

**Evaluation**

Patient-centred care is at the heart of everything we do at the Homerton. It was necessary to think about the patient’s perspective and ask whether what we were proposing was going to address patient need.

Comments from some of the patients and carers seen by the carers’ specialist show this is being achieved:

- ‘You were the only constant among changing nurses and wards. It was particularly helpful after mum was discharged to discuss and sort out queries that just weren’t so obvious when she was in her hospital bed’;
- ‘If I needed help and support, I knew you were there.’
- ‘Very reassuring at a very difficult time’;
- ‘It was good to know there was someone who could listen and really understand when things got rough’;
- ‘I felt hopeful, encouraged and relieved.’

Similarly, comments that evaluated the benefits adviser include:

- ‘I’ve bought a bread maker and oven and can make more nourishing meals’;
- ‘My quality of life is not good right now, but with the extra cash I can pay for things to improve it’;
- ‘I can save towards a more comfortable chair now’;
- ‘I can take cabs now and get about and do things I couldn’t do before.’

**Conclusion**

The benefits adviser and carers’ specialist have created a genuinely patient and carer-centred service. They often meet clients in the evenings or at weekends, in their own homes, when family members are not at work or when they can have all the information to hand. They provide a vital link across the complicated worlds of health and social care.

When asked about their hopes for the future, both the benefits adviser and carers’ specialist highlighted the single assessment process, in standard two of the NSF, as being crucial. Having a comprehensive, standardised assessment that spans health and social care is seen as

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**REFERENCES**


This article has been double-blind peer-reviewed.

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paramount. The hope is that the baseline and initial contact assessment will act as a case-finding process, and that carers’ needs and financial support will become an integral part of care – not merely an added extra.

Recognising the needs of carers is a national concern. Were it not for this army of informal carers, thousands of people of all ages across the country would have to be cared for in institutions and hospital settings. The NHS and social services would simply collapse.

Our starting point was having a carers’ policy at the trust. This gave us an element of corporate strength when bidding for resources – we needed the resources to reach best practice within the policy.

The second key stage was to talk to partner agencies such as the primary care trust and social services. The fact that we met to discuss intermediate care meant that we did not set up small, isolated satellite services, but instead viewed patients’ needs within a whole system. This then triggered discussions about financial support for our patients and led to the service agreement with the Benefits Advisory Service.

Case studies

Disability benefits muddle

Amelia Bond is in her late 60s and has learning difficulties. The residential home where she had lived for some years closed in 1998 and she was moved to sheltered accommodation. Because she had been in a care home, her benefits were limited. Unfortunately, no one thought to inform the disabilities benefit unit of her discharge.

Ms Bond was referred to the benefits adviser via the carers’ specialist after being seen on an acute ward during a spell in hospital. The benefits adviser discovered she had an extremely complex case on her hands.

Ms Bond’s disability living allowance (DLA) was not reinstated following discharge from residential care in 1998, furthermore, her circumstances had changed and she required extra support. The benefits adviser informed the necessary agencies of her discharge into the community and requested a review of her DLA.

Ms Bond received more than £8,000 compensation for the benefits she had missed out on since the residential home closed. She had gone without her entitled benefits for more than five years and could have sued the authorities. However, Ms Bond and her sister were simply happy that the carers’ specialist and the benefits adviser had been able to help.

As well as a general increase in her standard of living, Ms Bond now has visits from a mobile hairdresser and her sister can arrange for taxis to take her out, as she is unable to use public transport. Ms Bond now receives the higher rate of DLA and extra income support, and her income has increased by more than £80 a week.

Language barriers and unpaid pension

Nazir Ahmed’s first language was not English and his family was struggling when the carers’ specialist became involved after he had a stroke.

Many members of ethnic minority groups find it very hard to approach the relevant agencies for assistance and have great difficulty challenging decisions. The carers’ specialist referred the family to the benefits adviser.

She discovered that Mr Ahmed had been entitled to a retirement pension since April 2000. Unfortunately, the relevant agencies had failed to inform each other of this entitlement as both assumed the other was making payments. To make matters worse, they were deducting the money from Mr Ahmed’s income support because they assumed he was receiving the pension.

The benefits adviser also helped him to reapply for attendance allowance and was successful in getting him the higher rate due to the level of his care needs. In addition, Mr Ahmed received more than £6,000 in back-dated retirement pension.

Sadly, he died before he could enjoy the difference this would have made to his life.

Complex immigration issues

Michael Crowhurst was in his early 40s when he had a stroke. This caused severe dysphasia, leaving him unable to handle his own affairs.

His wife, who had recently arrived in the UK, did not know how the UK welfare system worked and the carers’ specialist spent a great deal of time exploring her needs, looking at her husband’s discharge wishes, and liaising with numerous people to meet those needs. The benefits adviser became involved quite early on, aware that issues such as housing and other benefits would take some time to process.

Mr Crowhurst received a letter from the benefits agency stating he had to pay back a social fund loan he had received. The benefits adviser wrote to the relevant section immediately and got this decision reversed, so the loan was no longer recoverable and deductions would not be made from his benefit.

The benefits adviser also applied in advance for DLA so Mr Crowhurst’s benefits would start being paid immediately after his discharge. Mr Crowhurst wished more than anything to be able to go home, but his disability was such that this was impossible and a new home was needed.

The carers’ specialist and the benefits adviser worked alongside the multidisciplinary team sorting out housing and disability benefits, and navigating the complex immigration issues.