

Providing effective and preferred care closer to home: A realist review of intermediate care

Abstract

Intermediate care is one of a number of service delivery models intended to integrate care and provide enhanced health and social care services closer to home, especially to reduce reliance on acute care hospital beds. In order for health and social care practitioners, service managers and commissioners to make informed decisions, it is vital to understand how to implement the admission avoidance and early supported discharge components of intermediate care within the context of local care systems. This paper reports the findings of a theory-driven (realist) review conducted in 2011-12. A broad range of evidence contained in 193 sources was used to construct a conceptual framework for intermediate care. This framework forms the basis for exploring factors at service-user, professional, and organisational levels that should be considered when designing and delivering intermediate care services within a particular local context. Our synthesis found that involving service users and their carers in collaborative decision-making about the objectives of care and the place of care is central to achieving the aims of intermediate care. This pivotal involvement of the service user relies on practitioners, service managers, and commissioners being aware of the impact that organisational structures at the local level can have on enabling or inhibiting collaborative decision making and care coordination. Through all interactions with service users and their care networks, health and social care professionals should establish the meaning which alternative care environments have for different service users. Doing so means decisions about the best place of care will be better informed and gives service users choice. This in turn is likely to support psychological and social stability, and the attainment of functional goals. At an organisational level, integrated working can facilitate the delivery of intermediate care, but there is not a straightforward relationship between integrated organisational processes and integrated professional practice.

Keywords:

Integrated care

Re-ablement

Community health care

Service delivery and organisation

Systematic review

What is known about this topic

- For decades there have been various service delivery models intended to enable service users to avoid hospital admission or leave hospital earlier.
- There is considerable diversity in the design and configuration of such 'intermediate care' services.
- Decision-making is hindered by a lack of common understanding of what intermediate care is, how it 'works', and how service delivery models can be implemented at a local level.

What this study adds

- An up-to-date and practical conceptual framework for understanding intermediate care.
- An explanation of the mechanisms that occur at service user, professional, and organisational levels, which can inform the design and delivery of intermediate care in local contexts.

INTRODUCTION

During the latter half of the twentieth century, efforts to integrate health and social care in developed economies have taken many forms in an effort to maintain or improve quality and safety (Armitage et al., 2009, House of Commons Health Committee, 2012, Institute of Medicine, 2001). 'Intermediate care' is a term popularised in the United Kingdom (UK) to describe services intended to prevent admission to hospital ('admission avoidance' - AA) and/or provide rehabilitation in, or nearer to, people's homes ('early supported discharge' - ESD). Whilst health and social care systems and workforce organisation differ internationally, the goals of intermediate care are shared by, for example, Australia's Transition Care Programme (Gray et al., 2012) and the Transitional Care Model in the USA (Naylor et al., 2013). Intermediate care is one of the many ways in which the integration of health and social care services has been pursued, and has been driven in part by the belief that comparable care costs less in the community than in an acute hospital (Iliffe, 1997, Leutz, 2005). Also, across developed economies characterised by increasing numbers of frail older service users, intermediate care is being delivered in care systems where service users expect the right to exercise control over their own lives and choice in the services they access.

Whilst systematic reviews of effectiveness suggest there are no compelling quality or safety reasons why intermediate care should not be used for adults with certain diagnoses (Forster et al., 2008, Griffiths et al., 2007, Hillier and Inglis-Jassiem, 2010, Langhorne et al., 2005, Shepperd et al., 2008, Shepperd et al., 2009), there is far less understanding about how to implement such schemes in particular local contexts that may differ in important ways from those in the original effectiveness studies. This lack of understanding may be one reason why there is so much variation in the design and configuration of intermediate care services and the terms used to describe them (Godfrey et al., 2005, Martin et al., 2004, National Audit of Intermediate Care, 2012, Wilson et al., 2008). Analyses of intermediate care have struggled to conceptualise an area that is so wide-ranging (Lees, 2004, Roe and

Beech, 2005, Stevenson and Spencer, 2002). Whilst Nancarrow et al. (2009) have described the practical components of intermediate care services, the lack of a conceptual framework hinders the design, long term feasibility and implementation of these services and adversely impacts on evaluations of intermediate care (Melis et al., 2004, Parker et al., 2000).

This paper reports a realist review conducted to develop a conceptual framework for intermediate care. Our review questions were:

1. What are the mechanisms by which community-based alternatives to acute inpatient care are believed to result in their intended outcomes?
2. What are the important contexts which determine whether the different mechanisms produce intended outcomes?

The primary goal of realist review is explanation-building, aiming to produce a contextualised understanding of the mechanisms by which interventions produce different patterns of outcomes (Pawson, 2006, Pawson et al., 2005) - in this case, the explanatory context-mechanism-outcome configurations relating to intermediate care. Central to the realist method is the identification and refinement of propositions about how a programme is supposed to achieve its intended outcomes, known as 'programme theories' (Chen, 1990, Rossi et al., 2004, Weiss, 1998). Realist review methods, as part of a broader family of theory-driven approaches, have been advocated for evaluating evidence about complex interventions and their implementation (Berwick, 2008, Davidoff, 2009), but consensus is yet to be attained in this emerging field about the form of expression of programme theories. We operationalised 'programme theory' as ideas about (i) what is going wrong, (ii) how to remedy the deficiency, and (iii) how the remedy itself may be undermined (Pawson et al., 2010). In this review, we use the conceptual framework developed (Figure 2) as a basis for understanding the processes by which intermediate care services are delivered, and identify those aspects where efforts to deliver effective services can become derailed. As the conceptual framework is at a higher level of abstraction than the programme theories, it helps to situate the theories within a broader range of factors and processes, as well as temporally. Our goal is not to specify how a particular model of care can be implemented,

but to provide an evidence-informed 'road map' of key factors for decision-makers to critically consider when planning the delivery of intermediate care services within their local context.

As our search terms were derived from a scoping of intermediate care literature drawn predominantly from the UK, our review represents a specific cut through published sources that emphasises intermediate care in publically-funded health and social care systems in northern Europe. The review is reported in accordance with the RAMESES publication standards for realist reviews (Wong et al., 2013).

METHODS

Based on scoping searches of databases, related article searching and key citation chasing, we developed a long list of terms used to describe services analogous to intermediate care. To identify a wide range of sources, no filters were applied in using these terms in database searches of Medline, Medline in Process, Embase, Social Policy and Practice, HMIC, British Nursing Index, The Cochrane Library, Cinahl, and Assia. Using a broad definition of the purpose, functions, structure and content of intermediate care (Table 1) we mapped sources grouped in each of a number of service user groups on the basis of their potential to contain programme theories, using criteria proposed by Ritzer (1991) and Roen et al. (2006) (see Supporting material file #1). We purposively sampled editorials, commentaries and grey literature reports so as not to miss programme theories from these sources (see Supporting material file #2). We constructed a table in which the emerging programme theories could be recorded, cross-referenced and commented upon. Health and social care practitioners, commissioners, and managers from our Project Reference Group provided feedback on a range of programme theories that was integrated into this table. Identified programme theories were used to inform the development of the conceptual framework. The flow of sources through the review and their use for identifying programme theories and developing the conceptual framework is shown in Figure 1 and Table 2. The conceptual framework developed from the programme theories is shown in Figure 2.

[Insert Table 1 about here]

[Insert Figure 1 about here]

[Insert Table 2 about here]

[Insert Figure 2 about here]

In consultation with the Project Reference Group, we selected three programme theories for refinement (see Table 3) based on their potential explanatory power and the likely availability of relevant evidence in one of five service user groups (older people, and people with heart failure, Chronic Obstructive Pulmonary Disease (COPD), stroke or cognitive impairment). We critically appraised sources using the Wallace et al. (2004) tool for assessing the quality of applied social policy research. Data from all the identified sources of evidence was extracted to data extraction tables. Synthesizing the evidence to refine the three programme theories was an interpretive process which used both data and analysis from all sources of evidence (Pawson, 2006). We have endeavoured to present our findings in a way that is clear and meaningful for a diverse audience of decision-makers. However, for readers who want to understand more about how we applied a realist approach, a more detailed description of review methods and the rationale for their use can be found in Supporting material file #3. The review was conducted in 2011-12.

[Insert Table 3 about here]

SYNTHESIS

We identified 38 studies suitable for refining the three programme theories. The intermediate care services examined in these studies were predominantly aimed at older people, or were generic rather than being condition-specific. Seventeen of the studies examined services offering both AA and ESD, and a further 17 examined ESD services. Only one study reported on an AA only service, whilst three studies were unclear about which service type they included. Table 2 summarises the characteristics of the included studies and their use in the review.

Collaborative decision-making with service users to facilitate re-enablement

Agreeing objectives of care

Agreeing the objectives of care with service users is not necessarily straightforward. Goals considered appropriate by professionals, within the structure of the existing local health and social care system, may not correspond with the goals of patients (Martin et al., 2005). For example, a low level of communication and negotiation with service users can lead to a mismatch between service users' and practitioners' goals (Wiles et al., 2003). A more positive example is provided by a Swedish home ESD service for stroke, where a close-knit team of rehabilitation professionals developed their 're-enabling' skills and a service user-centred approach. This fostered a more collaborative decision-making approach around goals that involved service users, relatives and professionals (Wohlin Wottrich et al., 2007).

In a combined residential AA/ESD service for older people with cognitive impairment, development of *care support* staff's skills was reported to be essential (Wilkie, 2011). In this study, developing these skills extended some way beyond educating support staff about a 're-enabling' approach. As support staff felt excluded from decisions about care planning for service users, a 're-enabling' approach required active engagement of all care staff in efforts to place service users at the centre of discussions about care (Wilkie, 2011). In summary, the professional development of care staff, including professional carers and support staff, appears to be important for enabling collaborative decision-making with service users.

Implementing the ideal of negotiated decisions may not be straightforward when service users' and professionals' views differ about their respective roles (Benten and Spalding, 2008, Small et al., 2007) or the appropriateness of goals of care (Hart et al., 2005). For example, staff in a residential ESD service for older people endeavoured to deliver care that was 're-enabling' through integrating functional rehabilitation into day-to-day activities. Patients co-operated but could not be said to be genuinely participating in decision-making about their care (Benten and Spalding, 2008, Small et al., 2007). Nevertheless, some health and social care professionals hold the view that the process of negotiation with service users plays an important role in promoting confidence and autonomy (Trappes-Lomax et al.,

2003). Consulting with service users who are dealing with the multiple health and social issues of old age may be less straightforward than for service users who have suffered a discrete (albeit serious) health event such as a stroke. This evidence suggests that desirable *functional* outcomes may still be attained for older people without good collaborative decision-making, but that collaborative decision-making may be far more important for attaining other health and social outcomes that are less to do with physical functioning.

Complexities of decision-making at a time of vulnerability

Decision-making about care can be particularly difficult for older people when they are feeling vulnerable and overwhelmed by the implications of their health condition(s). In these instances service users may hold on to what they are familiar with; for example, they may wish to stay in an acute care setting which they perceive as safer and more secure than another residential ESD option (Trappes-Lomax et al., 2003). The notion that it is possible for negotiation about the objectives of care to take place on an equal footing may be optimistic when service users are in a vulnerable state, even when professionals are doing their utmost to implement a service user-centred approach. Whilst collaborative decision-making remains a worthy goal, there are limits to how much a genuinely collaborative approach can be implemented where health and social care professionals also have an important role in acting in the best interests of vulnerable people in their care.

However, endeavouring to act in the best interests of service users could result in them feeling pressurised to return home before they felt they were ready. For example, for people entering a home ESD service following admission to hospital with exacerbation of COPD (which may provide respite for carers as well as support for management of the condition), some patients felt unable to voice their concerns about their ability to cope (Clarke et al., 2010). It is implied that this perception arose through a mixture of deference to medical authority and the difficulty for service users of explaining to health care staff why hospital could be preferable to home at certain times (Clarke et al., 2010). Similarly, at the end of a home ESD service, older service users felt unable to negotiate what they believed

to be a more tapered withdrawal of support services (Ryan-Woolley et al., 2004). This could lead to a sense of abandonment, as the experience for some older people who were still in a vulnerable state was that intermediate care support services just 'stop'. The extent of negotiation about the objectives of care is therefore dependent on both professional norms and the conventions of service provision in a locality - not simply the willingness or ability of practitioners to engage service users in decision-making.

Put simply, decision-making about ESD for service users at a time of vulnerability is difficult. This difficulty can limit the extent to which collaborative decision-making takes place when endeavouring to balance a service user's wellbeing with their preferences and fears, within current service configurations. Whilst service users may be able to balance their long-term wellbeing with their own fears about the difficulties of rehabilitation in retrospect, doing so at the time at which care is negotiated can be problematic and daunting (Godfrey and Townsend, 2008). For older people, feelings of distress or fear may make it problematic to try and engage in a complex decision-making process that may have profound implications for their future wellbeing (Manthorpe and Cornes, 2004). In tandem with a lack of awareness about the extent of their recent physical and emotional decline (Godfrey and Townsend, 2008, Manthorpe and Cornes, 2004), the loss of contact with close relatives or friends (Godfrey and Townsend, 2008), the implications of future illness (Godfrey and Townsend, 2008), and/or the loss of physical, emotional or cognitive abilities (Thomas and Lambert, 2008), this could manifest as over-ambitious ideas about what realistic goals might be (Manthorpe and Cornes, 2004). It could also result in an over-optimistic assessment about how being back in the home environment would enable a multitude of issues surrounding recent ill health to be resolved (Swinkels and Mitchell, 2008). The vulnerability of some service users at the point of decision-making makes it necessary for collaborative decision-making to be made together with service users' informal carers.

An ethnographic study of a home ESD service for older people, however, suggests that service users may simply have a longer-term perspective than health and social care professionals. Older service users can view recovery in the context of the trials and

tribulations of their whole life rather than the parts of which health and social care professionals are aware (Godfrey and Townsend, 2008). Service users may find it crucial to hold onto these longer-term goals in order to facilitate adaptation to changes in their wellbeing (Thomas and Lambert, 2008). Decision-making with service users therefore needs to recognise this long-term perspective, engage with the aspects of service users' lives that are of significance to them, and reach agreement on objectives of care that link with these goals that extend beyond the period of intermediate care.

Continuity of care in the health and social care system

The complexities of the health and social care system are commonly recognised. These complexities can impact substantially on efforts to involve patients in decisions about their care and achieve continuity of care between different service providers. A lack of communication with service users can result in them feeling disconnected from the care planning process and create unrealistic expectations about the nature or extent of health and social care available (Manthorpe et al., 2006). Service users may have sufficient trust in health and social care professionals in general and make a choice to 'leave it to the experts' (Manthorpe et al., 2006), but this is a decision that needs to be explicitly sought if misunderstanding and anxiety are to be avoided (Benten and Spalding, 2008). In this sense, consultation with the service user, *even about preferences surrounding consultation*, is central to achieving the aims of intermediate care. Whether the service user chooses to be involved fully, partially - or paradoxically even not at all - in the decision-making process, the process of explicit and ongoing consultation with them about their care remains central.

When discussing care objectives and the place of care, health and social care professionals may need to maintain an awareness of service users' prior experiences of community services. Service users who feel they have been 'let down' by promises of health and social care provision in the past are likely to be reluctant to take-up what they perceive to be similarly weak services (Petch, 2003). It seems to be essential to address this perceived risk about home ESD services where service users have previously had negative

experiences, as it constitutes a substantial risk to the feeling of safety in one's home that is valued so highly (Mitchell, 2011). Collaborative decisions about care and place of care can therefore only be made where service users feel confident in service standards.

Collaborative decision-making can be made problematic by the opacity of complex health and social care systems to service users and their families, making it difficult for them to understand what services are available and how they operate. This can lead to a sense of lack of control and disengagement from the decision-making process about transfer to a home ESD service for older people (Swinkels and Mitchell, 2008). Applied research linked such disengagement with a widespread view amongst health care professionals of older people as passive recipients of care (Joseph Rowntree Foundation, 2004), but a conceptually richer study challenged this view. Swinkels & Mitchell (2008) found that older people did not feel they had been deliberately excluded from decision-making about their care, but did experience a sense of helplessness at moving events in a complex system forward (Swinkels and Mitchell, 2008). This sense of helplessness was compounded by a perception that acute hospital staff were similarly helpless in moving transfer arrangements to a home ESD service forward (Swinkels and Mitchell, 2008). To engage in collaborative decision-making as far as they are able, the conditions need to be created for service users to see how their continuing input will actually have some impact on the arrangements for their future care.

Role of carers

The role played by service users' informal carers in discussing and agreeing care was rarely mentioned in service users' or health and social care professionals' accounts. One possibility is that these carers are already highly integrated into decision-making processes within the health and social care system and subsequently do not 'need' to be mentioned. However, another possibility is suggested by an Australian study of a home ESD service, which found that service users and professionals often *assumed* that a significant other would take on the role of informal carer. Discussions about care proceeded without

further examination of the willingness or ability of the significant other to take on this often demanding role (Dow and McDonald, 2007). This was particularly the case for women (who formed ~90% of the study sample), who reported taking on the role of carer as something that 'just happened' without an explicit discussion about or exploration of the role. Male carers, whilst far fewer in number, reported a similar experience (Dow and McDonald, 2007). Carers reported the significant impact that taking on the role of carer had on all areas of their own lives, with feelings of obligation and responsibility meaning that activities which took them away from the caring role were experienced as 'uneasy' (Dow and McDonald, 2007). Whilst the extent to which service users' family and friends are pivotal to continuity of care will vary by condition and life circumstances, it is clear that consultation with service users in isolation from these primary social and care networks is inadequate for organising continuity of care.

'Re-enablement' environments

Perspectives on the location that provided the 'best' environment for the 're-enablement' of service users often reflected differences in the priorities of health and social care professionals and service users. Professionals tended to focus on the suitability of environments to promote the recovery of functional abilities, whilst service users usually adopted a wider focus that considered the suitability of environments for promoting their wellbeing as a whole (of which recovery of functional abilities was a part). Professionals valued the home for the way that it enabled them to observe service users engaging in rehabilitation activities in their usual environment, thereby allowing problems to be addressed that would have otherwise been missed (Glasby et al., 2008, Nancarrow, 2007, Wohlin Wottrich et al., 2007, von Koch et al., 2000). There is a danger here that professionals prioritise a desire for service users to attain certain functional goals within a specified time period over service users' self-knowledge and desire to reach a wider set of goals over a longer, less clearly defined time period. However, health and social care professionals were generally able to promote the recovery of functional abilities within an

understanding of day-to-day activities that were meaningful for service users (Manthorpe et al., 2006). Also, health and social care professionals acknowledged how the home environment could enable continuity with social networks and provide continuity simply through being 'back on home territory' (Regen et al., 2008, Martin et al., 2005). Collaborative decision-making therefore remains central to organising successful ESD services. Forming an awareness and understanding of what motivates service users, and *jointly* considering the environment that is most likely to help them reach their goals can be central to engagement in re-enabling activities.

The importance of understanding service users' goals as about more than the recovery of functional abilities is illustrated by both a home ESD service for stroke (Wohlin Wottrich et al., 2007) and a combined AA/ESD service for older people (Godfrey and Townsend, 2008). The familiarity of the home environment was identified as supporting both the recovery of functional abilities and 'meaning' in service users' lives. Meaning was found in activities, relationships and social roles (such as grandparent or housewife) and could be fostered through a holistic approach to the person's wellbeing. The home environment provided a sense of continuity and meaning in service users' lives as a whole, thereby facilitating re-enablement (Wohlin Wottrich et al., 2007, Godfrey and Townsend, 2008). This suggests that the most 're-enabling' place of care for service users will be the one that best allows psychological and social, in addition to functional, continuity to be attained.

The potential role of home for providing 'structure, meaning, rhythm and a sense of belonging to lives' (Swinkels and Mitchell, 2008, p.50) and facilitating meaningful social engagement should not be underestimated. However, a desire to return home as soon as possible was not overwhelming for all service users, some of whom offered a complex account of what home meant for them in terms of its suitability or otherwise as a place for re-enablement. Some older service users favoured rehabilitation (in the shorter term) in a specialist environment where physical adaptations were already in place (Martin et al., 2005), suggesting a conceptualisation of home as a goal (to return to when well) rather than an environment in which to recover. This conceptualisation is echoed in Godfrey &

Townsend's (2008) interviews with older people who had used intermediate care services, which suggested that service users had mixed feelings about returning home at a time of vulnerability when this was so closely equated with having recovered. The impact of collaborative decision-making on outcomes is unclear in situations where service users feel such ambivalence or resistance to returning home, but the reviewed studies suggest that the validity of such feelings have to be recognised within any efforts towards collaborative decision-making.

Service users' knowledge about their chronic medical conditions and the difficulties of moving from hospital to home was not always appreciated by acute hospital staff. For example, a focus in a home ESD service on addressing the functional needs of service users with COPD could fall some way short of enabling service users to re-integrate with their prior social network (Clarke et al., 2010), resulting in the home environment being experienced as isolating and boring.

It was not uncommon for both hospital- and community-based professionals to view hospital environments as 'institutionalising' and disabling in contrast to the perceived benefits of service users' home environments (Glasby et al., 2008, Hart et al., 2005, Martin et al., 2005, Nancarrow, 2007), a view echoed by many older service users who associated hospital with dependence on others, a loss of autonomy, and additional risk (Swinkels and Mitchell, 2008). However, it is not clear whether this view is held because of the way that rehabilitative care is conventionally organised and delivered in hospital or whether *any* 'non-home' environment inherently limits 're-enablement'.

Where older people have rehabilitation over weeks rather than days, residential ESD could be highly valued for the way in which the location of care environments such as community hospitals allowed visits from family and friends (Grant and Dowell, 2002, Small et al., 2007, Trappes-Lomax et al., 2003). Such residential ESD environments also enabled a sense of a 'return to normality' through returning service users to the care of their regular General Practitioner (GP) whilst also retaining the sense of security that there were always care staff nearby (Trappes-Lomax et al., 2003). This is further evidence of the need for

health and social care professionals to understand the meaning of home and other care environments to individual service users. These understandings can differ as much within as between different patient groups, yet appear to be of substantial importance for explaining how service users can attain functional, psychological and social continuity. It is only by engaging with service users in an effort to understand these different meanings that joint decisions can be reached about the best environment for a person's re-enablement.

A 'home-like' environment with an emphasis on 're-enablement' can also be created, in principle, within a separate unit in a residential home. For example, a residential ESD service was valued by many service users as a transition point between hospital and home (Hart et al., 2005). However, contrary to the 'home-like' environment that had been created, researchers also observed a 'creeping institutionalisation' as rehabilitation professionals sought to expand the service through the development of, for example, a number of 'training kitchens' (Hart et al., 2005). This evidence suggests that some rehabilitation professionals experience a difficulty in attaining a balance between improving service users' outcomes and their own professional development (pursued through delegation of 're-enablement' care and expanding services). If this balance is not attained then services may *appear* to offer care that is more closely attuned to service users' preferences about objectives and location, but not actually attain this goal.

Ultimately, 're-enabling' environments may also be significantly about helping service users to marshal their own social and psychological resources to achieve continuity in their lives (Godfrey and Townsend, 2008). In an ESD service for stroke, the development of a trusting relationship between service user and professional was posited as crucial for supporting re-enablement and continuity in service users' lives (Wohlin Wottrich et al., 2007).

Impact of the local health and social care system context

Inevitably, the characteristics of the local health and social care system could significantly bound care options for service users. Decisions about these options were largely mediated by health and social care professionals using their knowledge of available

resources in the local system (Regen et al., 2008) to guide decision-making about the best place of care and negotiate the bureaucracy in order to access those services, funds or care (Martin et al., 2004). Professionals working in a locality over an extended period, such as GPs, can develop very fine-grained knowledge about the availability of different local services and the likelihood that these would benefit a particular service user (Grant and Dowell, 2002). In contrast, referral procedures that are difficult to understand can inhibit access to intermediate care (Regen et al., 2008, Nancarrow, 2004b), particularly when professionals are reluctant to place their trust in services they regard as unproven (Hubbard and Themessl-Huber, 2005).

Integrated working between health and social care professionals and carers

Change management within and between health and social care organisations

The integration of services, across both acute and community care in the health sector, and health and social sectors in the community, was frequently identified as requiring changes in both service organisation and professional practice (Barton et al., 2006, Glasby et al., 2008, Glendinning et al., 2008, Godfrey et al., 2005, Greene et al., 2008, Griffiths et al., 2004, Hubbard and Themessl-Huber, 2005, Nancarrow, 2004b, Nancarrow, 2007, Robinson and Street, 2004, Wilkie, 2011). For example, a combined AA/ESD service was not viewed by hospital practitioners as part of the system of care, thereby substantially limiting the extent to which integrated working could take place (Glasby et al., 2008). Inconsistencies between service perceptions at a strategic level, and the extent of integration (Barton et al., 2006, Godfrey et al., 2005) or service user focus (Manthorpe et al., 2006, Trappes-Lomax et al., 2003) at the level of practice, highlights the way in which service re-configuration requires intervention at a range of organisational levels. Health and social care professionals' reluctance to place their trust in novel care-providing services was identified as a barrier to integrated working (Glasby et al., 2008). Of course, professionals can find change unsettling - the rationale for work routines, roles and processes that were previously taken for granted may be challenged. There may be a fear that de-skilling or

disempowerment will result (Hubbard and Themessl-Huber, 2005, Towers et al., 1999), although this is by no means always the case as overlap in professional roles can be experienced as complementary and an opportunity to develop practice (Nancarrow, 2004b). However, the evidence suggests that development of services to deliver intermediate care in an integrated way requires effective management of change processes within and between health and social care organisations.

Managing this change process effectively entails a multi-component approach that operates at both local and strategic levels. The need to create each component in such an approach will depend on the extent to which current practice already encompasses it. The five components we identified in the literature on intermediate care are: engagement with staff; professional development; leadership; supporting organisational structures and processes; and active engagement of carers and voluntary services as part of the team.

Engagement with staff

An integrated approach at the level of organisations is difficult without collaborative care planning processes for individual patients. Encouraging and enabling both professional and support worker staff to contribute to planning care for individual service users was identified as important for realising an integrated approach (Glendinning et al., 2008). It is possible that such an approach communicates a recognition and valuing of practitioners' and support workers' experiential skills and knowledge (Baker et al., 2001) and thereby contributes to supporting front-line staff's autonomy in practice (Glendinning et al., 2008).

Professional development

We identified the importance of the working environment in helping professionals and support workers to develop professionally (Glendinning et al., 2008, von Koch et al., 2000). Regular face-to-face meetings of teams that included all grades of staff were reported to provide an important forum for communicating about service changes and providing support for the development of working roles (Glendinning et al., 2008), as was an approach that

maintained a distinct contribution for each professional group whilst allowing for a blurring of boundaries in other aspects of professional roles (Hubbard and Themessl-Huber, 2005). OneESD service for stroke held weekly team meetings for all health rehabilitation professionals involved in the programme with the aim of providing a forum in which these professionals could help, support, teach and learn from one another. The apparent success of these meetings was attributed by the researchers to the time and space they provided for professionals to learn new ways of working and adjust to the increased responsibilities that these entailed (von Koch et al., 2000). A home ESD service for older people identified a similar role for face-to-face meetings in facilitating the learning and development of support staff (Baker et al., 2001). This was echoed in a residential ESD service for people with cognitive impairment where explicit efforts were made to develop a shared understanding with care home staff and managers of what the intermediate care service could offer - this was viewed by the practitioner-authors as vital for the development of integrated working (Wilkie, 2011). The process of communication and of reaching a shared understanding between professionals, support workers and managers prevented the service from being viewed as a 'quick fix' intervention and enabled a longer-term, preventive, collaborative and trusting working relationship to be developed (Wilkie, 2011).

Whilst formal face-to-face meetings could make an important contribution to the development of working relationships, in a home ESD service it may be necessary for community staff to pursue informal working relationships with acute hospital staff. The development of this trusting working relationship was observed to facilitate communication and enable flexibility in service provision (Robinson and Street, 2004). However, our review did not find evidence about effective strategies which might foster such informal working relationships.

In other contexts, where combined AA/ESD services are provided, it may be appropriate to adopt other approaches that increase professionals' knowledge of intermediate care services and promote the development of working relationships between hospital and community staff. Such approaches may include post rotations (Barton et al.,

2006, Nancarrow, 2004b, Nancarrow, 2007), the development of inter-professional teams that provide experience of different ways of working (Nancarrow, 2004a), and social events in which health and social care professionals could meet in an informal atmosphere (Hubbard and Themessl-Huber, 2005). The evidence suggests that a range of approaches may be appropriate to promote integrated working, but that whichever is adopted, they must increase knowledge of others' practice and promote the development of working relationships.

Leadership

We identified the importance of organisational leadership both for providing a consistent sense of direction in the development and delivery of intermediate care services, and for managing working relationships between professionals and between professionals and support staff (Griffiths et al., 2004). Leadership could play a particularly strong role where traditional professional hierarchies or professional practices countered the ethos of integrated working or weakened a focus on service user outcomes (Griffiths et al., 2004). The commonly observed power differential between hospital and community staff, which can be accentuated by the way that pressure on acute beds can drive demand for intermediate care services (Cornes and Clough, 2001) may require bold and proactive action by leaders from one environment (e.g. community) to develop critical, but constructive, personal working relationship with leaders from another environment (e.g. hospital) (Robinson and Street, 2004). Leadership also had a strong role to play in establishing co-ordinated communication channels between community and hospital settings that enabled practitioners to link intermediate care services into the wider health and social care system of which they were a part (Greene et al., 2008). The evidence suggests that proactive leadership has an important role to play in developing services, constructively addressing taken-for-granted working practices and power relations, and providing the strategic vision that drives the development of structures that support service delivery.

Supporting organisational structures and processes

A number of key processes are important, but not sufficient, to achieve integrated working. For example, formal joint working arrangements (Glendinning et al., 2008), pooled budgets and shared communication and assessment systems (Manthorpe et al., 2006, Ryan-Woolley et al., 2004, Baker et al., 2001) were all identified as highly important, although there were sensitivities about shared assessment tools if these were introduced in a way that were seen as replacing rather than complementing professional expertise (Nancarrow, 2007). The drivers of practitioners' actions may need to be considered. For example, acute nursing staff's practice is likely to be evaluated on the basis of their provision of acute care, rather than their contribution to re-enablement care planning in conjunction with intermediate care staff (Robinson and Street, 2004). Whilst the timeframe for meaningful change towards integrated working to take place depended on the extent to which the above enabling factors were already present in a local system, a change process measured in years rather than months was considered realistic (Baker et al., 2001, Griffiths et al., 2004, Hubbard and Themessl-Huber, 2005). This was because change was required at the levels of local policy, management, and care practice (Griffiths et al., 2004, Hubbard and Themessl-Huber, 2005) and frequently entailed challenging established norms (Hubbard and Themessl-Huber, 2005).

Depending on local conditions, a delicate balance may need to be struck between driving change forward and excluding frontline professionals, who may feel either that planned changes undermine their expertise or introduce additional responsibilities that they do not consider to be part of their role (Hubbard and Themessl-Huber, 2005). The evidence suggests that formalised agreements about, and processes to support, integrated working are insufficient on their own. Co-ordinated engagement with health and social care professionals at multiple strategic and practice levels is required to challenge assumptions about how care delivery should be organised in a locality.

Changes in the way that services were commissioned could help or hinder the development of integrated working in intermediate care services with a collaborative

decision-making approach. For example, changing from 'bulk-buying' of task-oriented care to a service user outcome-focused model (in which services were delivered according to a care plan and billed retrospectively) required managers/commissioners to actively address the sensitivities about the move in power from commissioners to providers and service users (Glendinning et al., 2008). This shift in power required well-developed working relationships and trust between purchasers and providers, established and open communication channels, and administrative and financial management systems that supported the change in service commissioning and delivery (Glendinning et al., 2008). The extent to which professionals engage in integrated working can therefore be enabled or constrained not only by their employing organisation, but also other organisations and power relations in the system of which they are a part.

Active engagement of carers and voluntary services as part of the team

Carers and voluntary services are equally part of the 'integrated' team, yet are conspicuous by their absence from many (but not all) practitioner and service manager perceptions of health and social care teams (Dow and McDonald, 2007, Manthorpe et al., 2006). As carers may not share the goals of service users or the goals expressed in care plans, this can be a significant issue for integrated working, in particular for home ESD services. In particular, as carers are often one of the most significant people in a service user's life, they may play a significant role in setting expectations for re-enablement. A carer's identity, for example as a spouse or sibling, may lead to a perceived need to care by 'doing for' rather than 'enabling' their significant other, countering the 're-enabling' ethos of intermediate care (Martin et al., 2005). The nature of existing relationships within a person's home are such that a professional cannot simply 'over-rule' a carer's input (Martin et al., 2005). Professionals may find this mismatch in expectations highly frustrating and hard to deal with, resulting in some carers being labelled as difficult, resistant or obstructive (Dow and McDonald, 2007). Providing ways for professionals to address these frustrations and subsequently engage with carers and collaboratively develop care plans, is therefore vital for

the delivery of integrated working. Of course, this process may differ substantially depending on the agreement or otherwise between the initial expectations of carers, service users and professionals.

DISCUSSION

Developing a conceptual framework for intermediate care and identifying, developing and refining programme theories has enabled us to identify the broad mechanisms that occur at service user, professional, and organisational levels. Although we have not been able to identify the relative importance of each of these mechanisms, or distinguish between necessary and sufficient causes, our synthesis does provide a 'road map' of the complex set of factors that decision-makers should consider to make intermediate care as effective as possible in any given local context (Table 4). It can also be used as a 'diagnostic checklist' to highlight weaker areas of existing intermediate care provision for improvement, or as a stimulus for measuring the extent to which a service addresses these factors within a local care context. The progress made by this review towards the specification of mechanisms at individual and organisational levels can also inform the focus of future research.

We acknowledge that another review team may have made different judgements at key stages in the review process, or with the involvement of a different Project Reference Group. At the initial stages of developing the conceptual framework, we used a particular working definition of intermediate care to identify relevant published sources. As well as applying this particular definition, we also made judgements about their likely conceptual or descriptive richness, initially on the basis of the title and abstract alone. Therefore, whilst we endeavoured to be inclusive at this stage, we may have missed other rich and relevant sources.

[Insert Table 4 about here]

CONCLUSION

Our review has shown that intermediate care is both defined by and is believed to achieve its intended goals through a central focus on the service user. In particular, intermediate care is thought to 'work' by involving patients and their carers in collaborative decision-making about the objectives of their care and the place of care. Realising the potential of this focus on the service user requires action at both organisational and professional levels, so that service users develop confidence in the standard of intermediate care services available to them and believe that their input will be listened to and acted upon. In contrast to the 'crisis management' and economic drivers that have often characterised the development and implementation of intermediate care services, this suggests that service provision driven by the goal of providing proactive, holistic and person-centred care is more appropriate. Person-centred care has long been intrinsic to calls for health care system re-design (Bechtel and Ness, 2010, Bodenheimer et al., 2002, de Silva, 2014, Goodwin et al., 2012, Institute of Medicine, 2001). Our review shows that placing patients and their carers at the centre of intermediate care service development and delivery is a core explanatory element for how intermediate care 'works'. In this respect there is likely to be considerable overlap between the ways in which intermediate care 'works' and other novel ways of co-ordinating services at the interfaces of more well-established services such as integrated care (Bodenheimer et al., 2002, Oliver et al., 2014).

The findings of this review enable us to make two research recommendations, one relating to intermediate care and one methodological. First, intermediate care services are often implemented with the assumption that all service users would prefer to be in their own home, but this assumption does not take account of the different meanings that home can have for service users at different stages of their life. These meanings can have a strong impact on whether or not the provision of intermediate care services in a person's home 'works' or not, but our appreciation of these features is limited. Primary research is needed to characterise and understand these factors (which may have as much variation within as between diagnostic categories), how they relate to real practical limitations of living or

recovering at home, and how they can be incorporated into intermediate care service models.

Second, identifying programme theories and mechanisms from sources that are not explicitly theory-driven, or which simply do not provide adequate descriptions of the content and operation of services is problematic (Bonell et al., 2006). We need a greater understanding of how the primary research community can be motivated to provide fuller information about *how* and *why* evaluated services were designed and delivered. Better understanding would make explanatory reviews, like this one, more insightful for practitioners and policymakers in different situations.

We found using realist review to develop a conceptual framework for this complex area a challenge. This was not simply because of the cross-sectoral nature of the topic, nor the wide range of sources. Rather, our biggest challenge was *applying* a realist logic. Despite the growth in the number of realist reviews, few tools or techniques have been documented in detail. At each stage of our review we found it necessary to develop our own ways of identifying, marshalling and engaging with the sources. We therefore provide full documentation and explanation of how we applied a realist approach (Supporting material file #3) to enable other researchers to move more quickly to engaging with sources, and encourage them to critique and adapt the tools and techniques we have developed.

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Tables and Figures

Table 1 Working definition of intermediate care used for screening sources of evidence (from Godfrey et al., 2005)

Table 2 Included studies and their use in the review

Table 3 Programme theories refined in the review

Table 4 'Road map' of factors explaining the effective delivery of intermediate care

Figure 1 Flow chart of sources through the review

Figure 2 Conceptual framework for Intermediate Care

Supporting material

Supporting material file #1 - Criteria used for assessing conceptual-richness of sources

Supporting material file #2 - Sources used to identify programme theories

Supporting material file #3 - Detailed description of review methods

Table 1 Working definition of intermediate care used for screening sources of evidence (from Godfrey et al., 2005)

Purpose	Supports <i>transition</i> ; occurs at a critical point (i.e. on the cusp of the shift from independence to dependence, at the point of acquisition of a chronic illness or disability, or at the intersection of illness and frailty related to ageing)
Functions	A bridge between a) locations; b) health or social care sectors (or within these sectors); c) health states Views people holistically, as individuals in a social setting Time-limited (for example, 72 hrs; 2 weeks; 6 weeks)
Structure	Designs and embeds new routes through services (which enhance sensitivity to needs and wishes of service users)
Content	Treatment or therapy (to increase strength, confidence, and/or functional abilities) Psychological, practical and social support Support/training to develop skills and strategies
Delivery*	Care delivered by an interdisciplinary team

* Addition made by review team to original Godfrey et al. (2005) definition based on initial immersion in the literature; discussion at the first Project Reference Group meeting confirmed the perceived importance of this factor.

Table 2 Included studies and their use in the review

Authors [country]	Service user group	Type of intermediate care	Data collection	Participants	Framework	Refine PT1/2	Refine PT3
CONCEPTUALLY-RICH							
Hart et al. (2005) [UK]	Older people	Res. ESD	Interviews, ethnography	55	✓	✓	
Martin et al. (2005) [UK]	Older people	AA/ESD	Interviews	92	✓	✓	✓
Swinkels & Mitchell (2008) [UK]	Older people	Home ESD	Interviews	23	✓	✓	
Wohlin Wottrich et al. (2007) [Sweden]	Stroke	Home ESD	Interviews	13	✓	✓	
THICK							
Asthana & Halliday (2003) [UK]	Generic	AA/ESD	Commentary	226	✓		
Baker et al. (2001) [USA]	Older people	Home ESD	Observation	13 [†]	✓		✓
Barton et al. (2006) [UK]	Older people	AA/ESD	Mixed-methods evaluation	2253			✓
Benten & Spalding (2008) [UK]	Generic	Res. ESD	Interviews	8	✓	✓	
Clarke et al. (2010) [UK]	COPD	Home ESD	Interviews	23	✓	✓	
Cornes & Clough (2001) [UK]	Older people	AA	Interviews, Observation	8 [†]			✓
Dow & McDonald (2007) [Australia]	Generic	Home ESD	Interviews, survey	148 [†]		✓	✓
Glasby et al. (2008) [UK]	Older People	AA/ESD	Case studies, focus groups and interviews	82 [†]	✓	✓	✓
Glendinning et al. (2008) [UK]	Older people	AA/ESD	Survey, case study	207 [†]	✓		✓
Godfrey & Townsend (2008) [UK]	Older people	AA/ESD	Interviews	85 [†]	✓	✓	
Godfrey et al. (2005) [UK]	Older people	AA/ESD	Mixed-methods evaluation	5 sites	✓		✓
Grant & Dowell (2002) [UK]	Generic	AA/ESD	Interviews	27		✓	
Greene et al. (2008) [UK]	Older people	AA/ESD	Commentary, Survey	NR			✓
Griffiths et al. (2004) [UK]	Older people	Home ESD	Interviews	12	✓		✓
Hubbard & Themessl-Huber (2005) [UK]	Older people	AA/ESD	Interviews	34	✓	✓	✓
Joseph Rowntree Foundation (2004) [UK]	Older People	Unclear	Focus groups	NR		✓	
Manthorpe & Cornes (2004) [UK]	Older People	Home ESD	Interviews	35 [†]	✓	✓	
Manthorpe et al. (2006) [UK]	Older People	Home ESD	Observation, interviews, documentary analysis	64 [†]	✓	✓	✓
Martin et al. (2004) [UK]	Generic	AA/ESD	Survey	NR	✓	✓	
Mitchell et al. (2011) [UK]	Generic	Unclear	Interviews, survey	NR	✓	✓	
Nancarrow (2004a) [UK]	Generic	AA/ESD	Interviews, case studies	26	✓		✓
Nancarrow (2004b) [UK]	Generic	AA/ESD	Workshops	126		✓	✓
Nancarrow (2007) [UK]	Generic	AA/ESD	Interviews, case studies	26		✓	✓

Petch (2003)	Older People	AA/ESD	Commentary, interviews	N/a	✓	✓	
Regen et al. (2008) [UK]	Older people	AA/ESD	Interviews	82 [†]	✓	✓	
Robinson & Street (2004) [Australia]	Older people	Home ESD	Interviews, observation	NR	✓		✓
Ryan-Woolley et al. (2004) [UK]	Generic	Home ESD	Interviews, focus groups, field notes	40 [†]		✓	✓
Small et al. (2007) [UK]	Older people	Res. ESD	Interviews	19 [†]		✓	
Thomas & Lambert (2008) [UK]	Older people	Home ESD	Focus groups, observations, interviews	10 [†]	✓	✓	
Towers et al. (1999) [UK]	Older People	Unclear	Interviews, focus groups	NR			✓
Trappes-Lomax et al. (2003) [UK]	Older people	Res. ESD	Interviews	42 [†]		✓	✓
von Koch et al. (2000) [Sweden]	Stroke	Home ESD	Interviews	47 [†]		✓	✓
Wiles et al. (2003) [UK]	Older People	Res. ESD	Interviews	25 [†]		✓	✓
Wilkie et al. (2011) [UK]	Cognitive impairment	AA/ESD	Observation	45		✓	✓

Key:

† amalgamated participant numbers (from e.g. focus groups, interviews, observation)

ESD Early supported discharge

AA Admission avoidance

NR Not reported

PT Programme theory

Res. Residential

Table 3 Programme theories refined in the review

No.	Programme theory – Improved service user outcomes are achieved when:
1	The place of care (e.g. home, day hospital, community hospital), and timing of transition to it, is decided in consultation with the service user based on the pre-agreed objectives of care and the location that is most likely to enable the service user to reach these objectives
2	Health and social care professionals foster the self-care skills of service users and shape the environment so as to re-enable service users
3	Health and social care professionals work in an integrated fashion with each other and carers

Table 4 ‘Road map’ of factors explaining the effective delivery of intermediate care

Level of action	Who should take action?	Questions to ask
<i>Service users</i>	Service managers and commissioners Health and social care professionals	Do service users: <ul style="list-style-type: none"> • have confidence in the standard of intermediate care services they will receive • believe that their input will be listened to and acted upon Whilst collaborative decision-making with older people with complex acute-on-chronic co-morbidities may be important for attaining psychological and social improvements, it does not appear to be so important for attaining functional improvements during recovery from a discrete acute medical event such as stroke (i.e. in the absence of multiple chronic co-morbidities)
Health and social care <i>professionals</i>	Service managers and commissioners Health and social care professionals	How does service design enable or inhibit health and social care professionals to: <ul style="list-style-type: none"> • have detailed knowledge of the characteristics of local intermediate care provision and combine this knowledge with the needs and preferences of service users • establish the <i>meaning</i> which different care environments have for individual service users, and explore the implications this may have for decisions about the place of care that best allows both functional <i>and</i> psychological, and social continuity goals to be attained • engage with service users in planning longer-term goals that extend beyond the timeframe of intermediate care • acknowledge and engage with service users’ primary social and care networks • develop a trusting relationship with service users, in order to support continuity in their lives • balance advocacy and a duty of care with service user preferences about their care, through engagement in a collaborative decision-making process with service users
Health and social care <i>organisations</i>	Service managers and commissioners	How does service design enable or inhibit: <ul style="list-style-type: none"> • professionals to implement collaborative decision-making with service users • the co-ordination of the delivery of agreed care in a timely fashion