

For the Sake of their Health: Older Service Users' Requirements for Social Care to Facilitate Access to Social Networks Following Hospital Discharge

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Summary

Facilitating older service users' requirements for access to or re-engagement in social networks following hospital discharge is recognized in social care analysis and policy as critically important. This is because of the associated benefits for restoring physical health and psychological well-being. However, it tends to be a neglected dimension of current social care/intermediate care. Our paper draws on a qualitative study of voluntary sector hospital aftercare social rehabilitation projects in five UK localities, which focused on addressing this issue. Through examining older service users' feedback and experience, our study confirms the health benefits of social care facilitating access to social networks at this crucial juncture. By providing sensitive interpersonal interaction, advocacy and 'educational' assistance, social care workers supported older service users' re-engagement in a variety of networks. These included friendship, recreational and family groups, health care treatment programmes and locality based contacts and organizations. As a result, material, interpersonal and health care resources were accessed, which contributed to restoring and sustaining physical health and psychological well-being. The *process* of such social care also emerged as critical. This

included ensuring that objectives reflected service users' priorities; integrating 'low-level' home care; offering befriending; and challenging the pre-set time frame of intermediate care.

Keywords: hospital discharge, older service users, social networks, intermediate care

Introduction

This paper explores the forms of social care that older service users require after hospital discharge, to facilitate access to or re-engagement in social networks, and the implications for their physical health and psychological well-being. It does so by drawing on a qualitative study of pilot voluntary sector hospital aftercare social rehabilitation projects.

The period following discharge from acute hospital care is a critical juncture for the health and well-being of older service users—the major patient group receiving acute hospital care (Audit Commission, 2000). The precarious nature of the health of substantial numbers of this group is reflected in Government figures showing that within a month of discharge, 11–12 per cent of service users aged seventy-five and over are readmitted to hospital as emergency admissions (NHS Health and Social Care Information Centre, 2005). Sustaining recovery and the routines of home life in the post-discharge period can make heavy demands on service users' psychological resources, particularly when living alone and experiencing multiple health problems or impairments (Barnes and Cormie, 1995; Waddington and Henwood, 1996). Older service users may also be caught in a vicious circle concerning social resources. While needing the interpersonal, material and professional support that social networks can provide to promote recovery, depleted energy, relatively low social status and income can make these extremely difficult to obtain (Manthorpe *et al.*, 2003; McLeod and Olsson, 2006).

Social care has an important contribution to make to older service users' short and longer-term health and well-being following discharge, although such care provision is far from comprehensive (Commission for Social Care Inspection (CSCI), 2005a). The drive for social care to facilitate the swift discharge of older service users also reflects long-term policy goals to promote the most economical use of acute medical care (McLeod *et al.*, 2003), and to meet politically sensitive treatment targets (Bywaters and McLeod, 2001). Nevertheless, intermediate care has represented a major substantially funded initiative, not only to avert avoidable hospital admission and unnecessary length of stay, but to support recovery by addressing transitional needs for health and social care post discharge. It has mainly, though not exclusively, targeted older service users. Headlined as a major strategy in the NHS Plan (Department of Health, 2000), subsequently incorporated in the *National Service Framework for Older People* (Department of Health, 2001a), and with

detailed guidance through the Department of Health (Department of Health, 2001*b*), it has given a higher profile to social care practice following hospital discharge. According to the official brief, intermediate care post discharge should comprise:

- a structured programme of treatment/care to assist recovery, with the ultimate aim of service users being able to live at home, as independently as possible;
- a time-limited (usually maximum of six weeks) mix of health and/or social care input, as appropriate;
- provision on a residential or community basis; and
- a single multidisciplinary assessment.

Subsequent local and national evaluations (Petch, 2003; Barton *et al.*, 2006) demonstrate that the provision of intermediate care is characterized by diversity in forms, objectives, timescales and location and that it is more appropriate to talk of different types of intermediate care than to style it as a homogeneous operation. However, there is an emerging awareness that the following two dimensions require further recognition and review:

- its potential contribution to facilitating older service users' access to or re-engagement in social networks; and
- the nature of older service users' own requirements relating to this (Manthorpe *et al.*, 2003; Petch, 2003).

These two dimensions are the focus of our account. After briefly reviewing the association between access to social networks and older service users' physical health and psychological well-being, and older service users' own perspectives on this issue, we outline our research methodology. We then identify and discuss the main features of the spectrum of social care which older service users in our study required to facilitate their access to social networks, and the implications for their physical health and psychological well-being. Our findings are derived from a small-scale qualitative evaluation. Nevertheless, they highlight important issues for the social care agenda following hospital discharge.

Access to social networks, and health and well-being

Substantial evidence of the association between access to social support, and health and well-being, has accumulated through epidemiological and sociological studies. In reviewing this evidence, Stansfield makes a useful distinction between social support reflected in access to social networks and what he refers to as 'the functional aspects of support—that is, the quality and type of support that is provided by the network member' (Stansfield, 2006, p. 148). Quality of support may be assessed in terms of emotional, practical or informational support which, in turn, may boost self-esteem, and practical and financial resources. It

also comprises interactive behaviour, namely giving as well as receiving support (Stansfield, 2006). This fuller definition of the nature and role of social support is encapsulated in our use of the term ‘social networks’ and underpins our analysis. The exact mechanisms whereby access to social networks contributes to health benefits remain to be unravelled (Davey Smith, 1999; Halpern, 2005). However, three patterns highlighted by Stansfield (2006) have been related to older people’s health by McMunn *et al.* (2006):

- access to social support is associated with reduced risk of ill-health, such as helping to lower blood pressure and maintain cognitive functioning (Berkman and Glass, 2000, cited in McMunn *et al.*, 2006, p. 279);
- greater psychological resilience derived from social support assists in dealing with the demands of long-term ill-health and impairment (e.g. Berkman *et al.*, 1992; Cameron, 1996, cited in McMunn *et al.*, 2006, p. 279);
- extensive population studies have shown an association between relative access to social support and forms of social inequality permeating society, with higher socio-economic status associated with ‘higher levels of perceived social support’ (McMunn *et al.*, 2006, p. 279).

This last point also serves as a cautionary note. Social care input cannot reverse the effects of long-term adverse social conditions; at most, it may ameliorate them. Nevertheless, this may be of considerable importance to the well-being of the person concerned.

Older service users’ perspectives

Studies of how older people define their physical health and psychological well-being and the resources required for this endorse the significance of access to social networks, for health. Such accounts challenge ageist assumptions which equate older people’s health and well-being with the maintenance of minimal standards of personal care through social care input. Instead, they show that older people—in company with the World Health Organisation—define health in broad terms, extending beyond ‘not being ill’ to enjoying and negotiating the benefits for psychological and physical well-being of multiple dimensions of social networks: ‘. . . relationships, learning . . . transport, housing, contact—being comfortable’ (Joseph Rowntree Foundation, 2004, p. 4). This appears to hold true for older people in different circumstances and from diverse backgrounds (see Walker and Hennessy, 2004 and Walker, 2005). Older people also place prime value on interdependence. The opportunity to be ‘givers and receivers of emotional, social and practical support’ (Godfrey *et al.*, 2004, p. 213) in families, local communities and the wider social sphere (Phillipson *et al.*, 2001; Bywaters and McLeod, 2001; Grewal *et al.*, 2004) is regarded by older people as integral to well-being. We use ‘health and well-being’ to reflect older people’s meanings of these terms.

When achieving their goals necessitates social care assistance, older people challenge the notion that what they require is 'care' that places them in passive and dependent roles (Clark *et al.*, 1998; Secker *et al.*, 2003). Moreover, as the Government's own *National Service Framework for Older People* recognizes (Department of Health, 2001a), services need to take account of what older service users – as expert witnesses on their own situation – know to be their requirements for short and longer-term well-being. Otherwise, it is likely that services will fail to address older people's needs.

Our study

Our data are drawn from an evaluation of the effectiveness and sustainability of services provided by five Age Concern pilot hospital aftercare social rehabilitation (HACSR) projects, funded by relatively small start-up grants. The projects were located in five rural and urban settings. The evaluation did not aim to assess the effectiveness of 'social rehabilitation' as a model and method of practice per se, nor its impact on reducing hospital re-admission. However, in four critical ways, it provided the opportunity to study older service users' requirements for social care to facilitate access to social networks and support post-hospital discharge.

First, it provided feedback on older service users' views and experience related to social care following hospital discharge. Second, the HACSR projects in question were primarily framed in terms of enhancing older service users' engagement with social networks and the exchange of social support. Their explicit brief was to provide social rehabilitation (SR) as an integral part of social care after hospital discharge. The SR approach aimed to provide:

'Programmes of time-limited intervention to help them (service users) restore confidence and skills lost through injury, bereavement or other trauma or loss', and to 'focus upon motivation and the restoration of valued social roles and networks' (Le Mesurier, 2003, p. 7).

Therefore, the issue of access to social networks was central to practice and reflected in accounts and records. Third, paid workers supplemented by volunteers had provided the social care input. Although Age Concern (the voluntary agency in question) was not immune to resource pressures, the identity of the HACSR projects as voluntary agency initiatives, designed to draw on volunteer input, meant that they escaped the tightly timetabled restrictive agenda of pre-set categories for assessment or care services which typically frames the input of statutory social care practice (Manthorpe *et al.*, 2003). This narrower statutory social care brief might have marginalized the facilitation of access to social networks, making it more difficult for us to explore this area with service users. Fourth, the Task-Centred model of social work embedded in the SR approach (Doel and Marsh, 1992) meant that older service users were encouraged to specify

as precisely as possible their chosen objectives for the SR service. Hence, service users' requirements were central to accounts of service provision.

Methodology

Sample

Service users were customarily referred shortly before discharge, by nursing staff or hospital social workers, to Age Concern HACSR project workers who visited the wards. Feedback for our study was obtained from seventeen (to allow for attrition, target sample: fifteen) service users. The sample was randomly selected by project co-ordinators across the five projects, from service users who had completed HACSR input. It was not selectively stratified by age, gender, ethnicity or pre-existing health conditions. The target number was chosen to reflect the number of participants from whom it was feasible to obtain qualitative feedback, within the resources of the study, while allowing for a response from service users from all five projects. Respondents could either participate through a telephone interview or by postal questionnaire; thirteen preferred to participate by questionnaire and four requested an interview. Understandably, data obtained through questionnaires tended to be briefer than that obtained through interviews. Nevertheless, questionnaires yielded descriptive accounts by respondents of significant and valued features of the SR service. The data from the service users covered the background to their referral to the project, their requirements for social care, experience of the service and the extent to which they felt it had helped them to achieve their goals.

Statistical information on numbers of SR service users was embedded in statistics on more general hospital aftercare services across the projects, and therefore it was not possible to extract total numbers of SR service users. However, project co-ordinators agreed to randomly select a sample of ten completed SR service user case records per project, anonymized prior to analysis by the researcher. Such records provided further information on the process of SR service input. In the event, due to vagaries in selection, forty-four such records were analysed.

These data were complemented by interviews with the five project co-ordinators, who identified what they saw as the distinctive features of service users' requirements, illustrated by case examples. All participants gave informed, written consent.

Process of research design and data analysis

To reflect older service users' interests and perspectives, a representative from an Older Service Users' Health and Social Care Forum contributed to all aspects of the research design and process. Qualitative data from semi-structured interviews, questionnaires and case records were analysed thematically in relation to specific research objectives.

Service users' profile

Age. The age range of service users was from fifty-seven to 101. Most were in their seventies and eighties, with a few either in their sixties or nineties.

Gender. Only two out of seventeen service users completing interviews or feedback questionnaires were men. In the sample of case records, there were also fewer men (eighteen) than women (twenty-six). As these figures relate only to our sample; they cannot be assumed to be statistically representative. However, as older women in their seventies and eighties live alone and experience poorer health and greater incidence of impairment (Arber, 1999), this may be reflected in uptake of the service.

Ethnicity. Only one member of a minority ethnic group was included in our sample, reflecting feedback from project co-ordinators that a disproportionately low percentage of members of minority ethnic groups accessed the service. This issue serves to highlight the persistence of inequality of access to community social care services.

Sexual orientation. In two locations, the voluntary sector organizations in which the HACSR projects were located were running initiatives to consider the specific service requirements of older gays and lesbians. However, records contained no information relating to service users' sexual orientation. Nor did this emerge as an issue in interviews or questionnaires.

Socio-economic position. No information was kept by the projects about either service users' income or their former employment. Therefore, it was not possible to clarify across the larger sample the influence of limited incomes on requirements for preventive care and the importance of the HACSR service being free at the point of use. However, the importance of these issues was reflected in feedback from individual service users.

Household composition and informal care. Nearly all the service users lived alone (fifty-six out of sixty-one). The five exceptions lived with their spouse. In only four cases did service users or records identify them as receiving a substantial amount of informal care: in each case, from a spouse. In a further few cases, a daughter or son was noted as 'living nearby', but was not identified as a carer. There were occasional references in project records to social services' input being received but this was not mentioned by service users in telephone interviews or questionnaires.

Health and impairment. Our sample's experience reflected two characteristic features of health and impairment among older service users requiring social care following hospital discharge (McLeod, 2004). Ill-health leading to the most recent A&E attendance or hospitalization was associated with long-term conditions such as heart disease. Health issues also tended to take the form of multiple problems combined with various forms of impairment such as stroke, together with hearing impairment and heart conditions. There was, however, little evidence of service users with Alzheimer's disease using the HACSR service. Feedback from project workers noted this situation, but did not clarify

why it should be so. Where impaired memory was mentioned, this was usually associated with another condition.

Safe transition: essential preliminary to re-engagement socially

The essential preliminary to older service users re-engaging with social networks following hospital discharge was safe transition between hospital and home. Feedback indicated that older service users were at risk in this respect in two important ways. First, several project co-ordinators alluded to encountering service users whose chances of health had been prejudiced because they had been discharged too soon and were too ill to cope at home. This scenario may have been reflected in the statistics on early emergency re-admissions for older patients, referred to earlier. Project co-ordinators believed that this problem had increased recently because of bed occupancy pressures in hospitals. Their concerns echoed those of the Commission for Social Care Inspection (2004) in reviewing a major initiative to speed up hospital discharge: Delayed Discharge legislation, whereby local authorities incur fines when service users remain in hospital due to the absence of community care arrangements to support discharge. The Commission found that while discharge had been speeded up, where services were inadequate to underwrite requirements for recovery, service users' well-being could suffer.

Secondly, project co-ordinators gave several examples which illustrated the need for improved levels of funding and co-ordination of health and social care services, to avert risks to health in the transfer from hospital to home. This finding echoed the concerns of the CSCI regarding 'gaps and shortfalls in service availability' that, in some locations, undermined recovery (2005a, p. 2):

One Social Rehabilitation worker had made an appointment with a potential service user for the morning after her discharge. The service user had multiple health problems and could not walk. When the Social Rehabilitation worker arrived she found the woman sitting in her hallway. She had been left at the bottom of her garden drive by the hospital transport the day before. Despite her leg being in plaster, she had managed to get herself into the house but could not get anywhere else. She had sat, in her hospital clothes, on an upright chair in her hall all night, without food or drink (Project A).

Assistance with 'practical' home care/personal care and aids

A large proportion of service users (ten out of seventeen) who gave direct feedback identified needing 'low-level' practical assistance in the home from the SR project. Typically, this comprised vacuuming, general cleaning

and shopping. They described this input as not only assisting their recovery by maintaining personal and home care when they were physically incapacitated, but also as helping to restore their morale in a situation of social isolation:

I was in quite a lot of pain also I was very depressed . . . it was a wonderful help which got me through a very difficult time. I had no family or close friends (Project C).

Several service users would have welcomed the extension of this service which was often provided by volunteers, beyond the two months or so of the project. As Clark *et al.* (1998) have commented, service users who have spent a lifetime keeping their home tidy and clean can find a deteriorating domestic environment depressing. If service users risk their own safety or well-being by trying to rectify the situation, this can further jeopardize recovery or health longer term. Direct home care provision did not fit the 'classic' SR service model focusing on service users gaining access to social networks and assisting service users to undertake tasks themselves gradually. However, project co-ordinators recognized that it was in service users' interests to meet this need, and accepted it as integral to the SR service. They also appreciated that it could be a prerequisite for service users being able to engage in social contact outside their home. As one project co-ordinator put it:

Quite often people say, 'The thing I would most like help with is cleaning, because then I have got a bit more time perhaps to go out' How the home looks to some people is so important, it gives them the confidence to face the world again (Project C).

The CSCI has also recognized that for social care to make its optimum contribution to older service users' well-being, 'lower level' preventive input needs to be welded onto 'acute' service provision typified by intermediate care:

A genuinely comprehensive preventive service needs to extend beyond the provision of intensive care to incorporate more simple, practical support for the wider community of older people, with the aim of maintaining and enhancing well-being and quality of life (CSCI 2005a, p. 6).

This basic level of home care that service users identified as a high priority is often a low organizational priority and the level of care most vulnerable to social services cuts (CSCI, 2005b).

Advocacy to assist access to material and social resources

As discussed earlier, hospitalization can mark the onset of further serious health problems and a greater degree or complexity of physical impairment. In this context, there were several examples in which service users needed social care project workers to act as advocates in negotiations with key organizations and networks, to obtain material and social resources important to their health and well-being.

Following hospitalization for a further stroke, one service user described her relief that:

The (project) visitor did ensure that I had all financial benefits to which I am entitled (Project B).

Another service user had been expected to go into residential care after leaving hospital. However, she had always been very independent and insisted that she did not want this. She had dysphasia (a profound hearing impairment) and some degree of cognitive impairment when tired. She could not manage paying bills and often forgot what she had gone for when out shopping:

The SR worker accompanied the service user to the bank and facilitated discussion between her and the bank manager about how paying the bills could be managed. Obtaining food was also problematic. The voluntary agency's shopping service offered a solution, but involved using the telephone. As well as finding suitable adaptations for the phone, the SR worker arranged for a worker associated with the shopping service to be trained to understand the service user on the phone. She also negotiated arrangements for the service user to telephone at her preferred times. Eventually the service user was able to audio-order and use aide memoires concerning what she wanted to purchase (Project C).

A SR worker enabled a service user to access his favourite former hobby—fishing, despite the onset of long term physical impairments. The service user could no longer drive to the fishing plots or cast his line. Using her advocacy skills, the SR worker contacted some fishing clubs and found people willing to drive the service user regularly to fish, bait his line and give other help where needed. The service user's physical health and stamina were recorded as improved, as was his emotional well-being on being able to resume a former activity and social life that had previously seemed permanently closed to him (Project E).

Social care as 'educational' assistance

Unlike advocacy, educational assistance to help service users acquire skills which they have never needed before, or re-acquire skills forgotten or 'lost' through lack of confidence or practice, is not conventionally provided either directly by social workers or through services arranged by them. Nevertheless, the importance of incorporating educational approaches in post-discharge care has been highlighted in Parker *et al.*'s (2002) systematic review of discharge schemes for older people. The greater flexibility of voluntary sector social care interventions (Manthorpe *et al.*, 2003) may also have played a part in some forms of educational assistance being incorporated into practice. Without them, it was clear that considerable barriers to social life would have remained for service users and also that they would have been denied opportunities for reciprocal support:

One service user wanted to resume visits to the betting shop which had been the hub of his social life before hospitalisation. However, his seriously impaired mobility necessitated use of a taxi and he had no experience of using taxis. The volunteer provided basic instruction and soon the service user was able to order taxis and resume his former life (Project C).

Another service user developed dysphasia following a severe stroke and had to relearn how to use a telephone. This was partially solved by the provision of a telephone aid, but the volunteer also sat with the user on a number of occasions to help her with the practical processes involved. The service user was eventually able to keep in contact with friends and shop by telephone (Project D).

In several cases, service users needed reassurance and encouragement from project workers to begin or resume using mobility aids:

One service user had a mobility scooter but was too nervous to drive it. She and the project worker agreed that the worker would walk alongside her for a couple of trips. After this the service user was able to drive the scooter independently (Project A).

Continuing car use has been shown to be of considerable importance for older people's social inclusion (O'Neill, 1996). However, in several cases, service users had been afraid of driving their car and wanted the project worker to accompany them a couple of times to help them overcome their anxiety. As one project co-ordinator commented: 'It's just having someone in the car with them' (Project A). The service users had then felt able to resume driving normally.

Addressing psychological barriers to entry to social networks

In addition, some service users needed assistance to tackle psychological barriers to entry to social networks. Meeting these requirements clearly needed sensitive, painstaking, interpersonal contact on the part of the workers. Interpersonal intervention of this kind has been identified as crucial to encouraging older service users to communicate the true nature of their requirements for social care following hospital discharge (McLeod and Olsson, 2006). The skills required also reflected in part what Croft and Beresford have identified as a core feature of social work in service users' interests:

What distinguishes social work is that it operates at the junction of our personal lives and civil status . . . It addresses both our psyche and our understanding of and dealings with the social world we inhabit (Croft and Beresford, 2002, pp. 391–2).

Project workers' assistance here represented an individualized solution to forms of discrimination embedded in social relations more generally, which limited service users' social inclusion. The examples that follow concern gendered

patterns of behaviour, and the stigma associated with mental distress. Nevertheless, for the individual service users concerned, it provided an important means of redressing these power imbalances, played out in individual fears, which had obstructed their engagement in social networks. This process also embodied a task-centred approach in that it included the agreement of clearly defined goals reflecting service users' priorities, and manageable stages of activity to reach such goals (Doel and Marsh, 1992):

After the death of her husband, one service user could not go outside without holding someone's arm. Ultimately the goal was for her to feel confident enough to go out on her own, but the first task towards this was just walking down the drive without linking arms. The next goals were walking from one lamp-post to another, then walking to the local shops, in each case accompanied, but not linking arms. Eventually the woman had acquired enough confidence to go on holiday with her family (Project E).

Another service user had attempted suicide and this had received considerable publicity locally. He was convinced that people he passed in the street knew about the attempt and were staring at him. He had therefore ceased going out. The project worker established a supportive relationship with him. She eventually persuaded him to accompany her on a short walk down the road. They progressed to walking around town. He was very nervous for some months, but eventually gained enough confidence to resume walking on his own. He received 'a good year's worth', of project support but the worker felt that the service user had been 'brought back from the brink' (Project A).

These accounts illustrate how such assistance to re-enter social networks reinforced service users' personal identities and constituted an important resource for their mental health. Benefits for physical well-being included closer oversight from family members, increased exercise and reduced risks of further suicide attempts.

Access to health care organizations and networks

Alongside assistance to access social networks more generally, older service users also required assistance to access specialized health care providers, to meet a variety of identified health needs. Ageist and disablist assumptions and the absence of pro-active initiatives have been evidenced more generally as constituting barriers to older service users taking up both preventive and rehabilitative health care (O'Neill, 1996; Khaw, 1999). One volunteer agreed to provide personal support to ensure that a service user kept up his exercise programme following cardiac surgery. A service user with impaired mobility and sensory impairment was accompanied to the dentist to commence regular dental treatment, with the project worker facilitating her communication. Another service user recovering from a stroke and living alone was helped to access follow-up hospital appointments.

Choice, friendship and time to care

Choice

Running through service users' accounts were features of the *process* of intervention that they valued. A key theme was their appreciation of the degree of choice of objectives and service delivery offered by the project. The Social Rehabilitation approach was anti-ageist, resisting threats to well-being from assumptions that older service users would fit into 'standard issue' community care services (Levenson, 2003). An example of the benefits of this approach concerned a ninety-four-year-old service user:

The service user had been encouraged to attend a day centre. However, the transport arrived much earlier than she wanted to get up. She felt that getting up a bit later in the day was one of the privileges of being older and retired. She told the project worker that anyway she would prefer to be accompanied to the park so that she could get used to going on her own. The worker started by putting the service user's electric wheelchair into her own car and driving to the park, then accompanying the woman while she went around the park using the wheel chair. This was an important aspect of the user's recovery of self-confidence and independence. She described the lift to her spirits, 'through being in touch with nature: the trees and the birds' (Project A).

Friendship

Service users' appreciation of the quality of interpersonal contact that volunteers offered radiated from their feedback. It was epitomized in the following comments:

A real person comes into your home and becomes your friend (Project A).

I'd just been left before (after her previous three strokes) and it was quite depressing. This was better—much better. His visits were exactly right . . . I'm a positive person but I found it difficult to be confident again. The reassurance from 'S' helped . . . He also helped with my relationships with others. I could be more patient with my daughter and cousin and other people as I talked about my thoughts with 'S' (Project B).

Several studies have highlighted that, despite goodwill, both the time and the brief to develop rewarding interpersonal contact may more readily characterize voluntary sector social care intervention than comparatively instrumental statutory service input (Waddington and Henwood, 1996; Andrews *et al.*, 2003; Manthorpe *et al.*, 2003). The prime aim of this project was not to provide a befriending service, but to facilitate access to social networks. However, in the context of relative social isolation, characteristic of substantial populations of older service users (WRVS, 2004), the elements of contact with a friend, provided by interaction with project workers, were particularly valued by service users. In its own right, such contact could therefore be seen as embodying one

of the aspects of social networks—friendship—which has extensively documented benefits for health (Halpern, 2005).

Time

While service users were happy with the frequency and length of visits, averaging one to one-and-a-half hours, weekly, the one complaint expressed by the majority was that the duration of the HACSR service—six to eight weeks, on average—was too short. Their first reason for this was that they had still felt unable to cope without assistance when the service ended. (Cornes and Manthorpe's (2004) evaluation of Help the Aged combined statutory and voluntary sector intermediate care projects also found that service users' state of health meant that health and social care input needed 'to stretch beyond the six-week "rule"' (p. 22.)) Second, service users regretted the loss of the quality of friendship that had characterized personal contact with project workers, at the end of the relatively short timescale of the project. This served to underline how valuable it had been to service users. In voicing their complaint, service users were not unmindful of resource constraints. For example, a couple mentioned that it might be worth cutting the length of visits (which they were happy with) to half an hour, in order to extend the length of contact overall.

One pragmatic response to this, shared by the project co-ordinators and advocated by Cornes and Manthorpe (2004), is to recognize that the characteristic six-week time limit for intermediate care (Barton *et al.*, 2006) is an arbitrary period shaped by resource issues, and to be more flexible, budgets permitting.

The Social Care Institute of Excellence's (2006) systematic review of qualitative studies of older people's views of hospital discharge also recognizes that the period of recovery may be slower than six weeks, partial and marked by increasingly complex health problems and impairments. Accordingly, the review argues that older service users in this situation may well be undertaking a major enterprise: '... longer-term life planning . . . for which they require information and support' (Social Care Institute of Excellence, 2006, p. 41). This suggests that social care post discharge should not simply be conceptualized as a short-term intensive intervention, based on assumptions that recovery is 'complete', after six weeks. To maximize older service users' subsequent engagement in social life, the time frame for social care needs to include a routine review, which may, if appropriate, lead to interventions being extended or new services being provided.

Conclusions

Our findings are derived from a small-scale study of older service users' experience and feedback. Nevertheless, they underline the importance of access to

social networks following discharge from hospital, in the interests of service users' health and well-being. Access to social networks meant obtaining basic material and physical resources for health, such as money, food and exercise; acquiring social resources of fundamental importance to psychological and physical well-being, such as supportive engagement in social networks; and accessing health care services critical to health maintenance and recovery.

Older service users' feedback and experience also suggested that in order to facilitate such health-promoting access to social networks, they required social care to take certain forms. Before highlighting these, it is also important to note that our study confirmed that there are certain essential preliminaries to this process:

- older service users should not be discharged from hospital when too ill to cope; the Department of Health's own figures on older service users' emergency re-admission within a month of discharge indicate that this is false economy, setting aside the psychological and physical distress that may be needlessly induced (McLeod and Olsson, 2006);
- health and social care services need to be sufficiently well funded and co-ordinated at the point of discharge, to ensure that the transition to home is not a health-damaging experience;
- in the interests of sustaining both short and longer-term health and well-being, assistance with 'low-level' personal care, where necessary, needs to be integrated into 'intensive' intermediate care on an extended basis;
- equalizing access to services remains a key priority.

In respect of older service users' engagement or re-engagement in social networks, our findings indicate that whether voluntary or paid, social care workers aiding older service users need to be able to undertake a range of interpersonal interventions. Those featured here comprised advocacy, education and interpersonal contact attuned to addressing psychological barriers to greater social integration. The skills required to undertake this spectrum of practice have implications for the training agenda as well as for the induction and support of volunteers and paid workers. As Lymbery (2004) has argued, in the interests of older service users' well-being, there is a need to maintain a comprehensive, as opposed to a 'narrowed down', approach to coverage of potentially relevant community care interventions.

Older service users also highlighted that social care input needs to be sufficiently flexible to enable them to access a variety of social networks in order to restore and/sustain well-being. Networks associated with friendships, localities and hobbies, as well as organizations providing commercial, welfare rights, home care and health care services, are all featured here. Evidence from broader studies indicates that incorporating voluntary sector involvement may currently enable this requirement to be met most effectively (Manthorpe *et al.*, 2003).

Finally, the evidence from our study suggests that the *process* of implementing social care to facilitate entry or re-entry to social networks at a critical juncture

for service users' health also needs to be characterized by certain features. These include setting objectives that reflect older service users' own priorities; personal engagement on the part of social care workers that has the quality of friendship—in a context in which it may represent service users' best chance of access to this—and resetting the time frame and the 'acute mode' of intermediate care's brief.

Costing preventive services such as this is complex and rarely even attempted but it is clear that these conclusions are not cost neutral for health or social care. However, social care that facilitates older service users' access to social networks, following discharge from hospital, can contribute to changing this transition from a threat to health and well-being to an opportunity for it.

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