



**Intermediate Care Learning Network  
Intermediate Care Demonstrating  
Progress**

**17th March 2010**

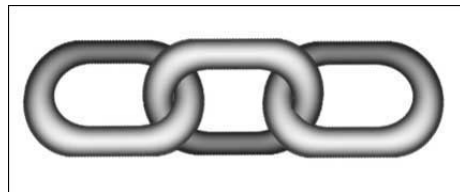
## 1. INTRODUCTION

This report from the Intermediate Care Network, Intermediate Care Demonstrating Progress conference summarises the contributions made on the day, highlights the progress made by the demonstration projects and acts as a base for the development of guidance on Intermediate Care in Scotland.

## 2. PRESENTATIONS

Brian Slater introduced the objectives for the day, which was designed to

- Share progress and learning from the Intermediate Care demonstrators and other partnerships.
- Consider approaches to evaluation.
- Outline the key strategic context for Intermediate Care in 2010 which includes Reshaping Care of Older People, the emerging Dementia Strategy, Outcomes approach to Community Care and the Quality Strategy.
- Consider key areas to be included in the development of guidance on Intermediate Care for Scotland using the expertise of participants
- Use the skills, experience and expertise of the network to inform and advise on future development of Intermediate Care models in Scotland.



### 2.1 Strategic Context

Margaret Whoriskey outlined the strategic context including evolving and developing work on:-

- The Quality strategy  
Reshaping care for older people
- The Dementia strategy
- The Carers strategy
- Shifting the balance of care
- Outcomes focus

She reminded participants of the draft NHS Quality Strategy 6 pillars of quality which will inform development of high level outcomes and measures, all of which have resonance for effective intermediate care.

Margaret reported that the Reshaping Care for Older People public engagement programme will be launched on 24<sup>th</sup> March. Workstreams within

Reshaping Care with specific links to Intermediate Care include Pathways of Care, Care at Home and Care Homes.

Participants were reminded of the demographic and economic challenges which face Scotland in the future and which innovative intermediate care models need to address.

### 2.3 Evaluating Intermediate Care

Pete Knight presented the challenges and practical constraints of evaluation. He outlined that the main evaluation are to demonstrate that the intervention or maintains outcomes economically or for lower important context in current financial climate.



aims of  
improves  
cost –

He also detailed the need to measure and link and effect of interventions and outcomes and to measure as closely as possible but also makes some assumptions.

cause  
to measure as closely as

Pete presented a short guide derived from work by Paul Leak on how to evaluate interventions including:-

- Ensuring clarity of outcomes
- Measuring linking cause and effect
- Ensuring that results are
  - Generalisable
  - Controlled
  - Measureable

JIT has developed an evaluation framework to inform local service redesign/development and is available on JIT website framework)  
<http://www.jitscotland.org.uk/action-areas/delayed-discharge/>

### 2.4 Intermediate Care in Practice

The conference heard from 5 Intermediate Care Demonstrator projects and Orkney, which had been supported by JIT in taking forward their own Intermediate Care service.

#### **Edinburgh “The light bulb moment ...”**

Elsbeth Donaldson highlighted the disparate services and interrelationships which a review of Intermediate Care services in Edinburgh had identified. Of the formally labelled



Intermediate Care services, many emerged from projects and are disjointed with small staff groups and a lack of critical mass. This was a theme which was recognised widely across the room. Elspeth identified the need to ensure linkage with a complex range of services and developments; consider partnership context for intermediate care; rationalisation of information management and information sharing and cultural issues across organisations and professional groups.

Fiona Stratton outlined the approach to the intermediate care demonstrator in Edinburgh with a focus on the 'Safe Home' project. This involves provision of OT assessment in A&E on a 7 day basis to target effective acute medicine for the elderly pathway. This work links to review of day hospitals underway; implementation of reablement home care services and telecare and falls pathways.

Edinburgh introduced Talking Points, Personal outcomes Approach to Assessment, Care Planning and Review (add web link) initially as part of the evaluation of intermediate care, but after initial caution (and a "light bulb" moment or two), Talking Points has started to change people's way of assessment and in informing their conversations with service users and carers.

### ***Fife 'Sustainability'***

Fiona Mackenzie described the 3 key strands of the Fife demonstrator programme:-



- Workforce training and development at several levels for a significant critical mass of staff and involving carers including staff participation in the Edinburgh MSc Integrated Service Improvement course; Dementia Studies and SVQs.
- Pharmacy – a half time post established to develop and support of models of care and links between intermediate care and pharmacy including analysis of data on pharmacy as a factor in admission to hospital.
- Extended Hours Access - Project staff have worked hard to achieve some extended access and increase the Kaiser pyramid of discharge at evenings and weekends. Out of Hours evaluation and engaging staff around changing how they worked had been problematic initially.

Evaluation was built in at the start with each strand separately evaluated using the JIT evaluation framework which has been very helpful, and the

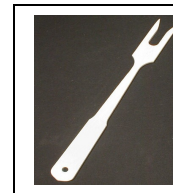
Intermediate Care Capability Framework.(web link) The IoRN was used with individuals accessing intermediate care and it has demonstrated significant improvements at the ends of almost all episodes of care. In addition there has been a focus on patient experience and appreciate enquiry supported by organisational development department.

Other emerging evidence shows that the profile of Intermediate Care has been raised, that staff value the investment in their training and development and are moving more freely towards 7 day working from an office hours culture.

A Project Board has overseen the development and implementation of the demonstrator programme with a sustainable action plan developed.

### ***Perth and Kinross “A 2 pronged approach”***

Audrey Ryman, Pam Baxter, and Evelyn Campbell described the demonstrator in Perth and Kinross which comprised:-



- Prevention of admissions from care homes
- Early supported discharge service from Perth Royal Infirmary – 7 days per week

In an admittedly small pilot, Audrey identified that:

- 15 patients had been admitted to the early supported discharge service
- 2 admissions were prevented
- 1 care home participated in training and education
- 72 health workers were trained in dementia and delirium (also enablement and rehab for the social care officers)

Whilst it is difficult to generalise results, a detailed project evaluation will be available at the end of March focusing on reduction on bed days (14 bed days per patient less), fewer in-hospital transfers, decreased emergency admissions, reduction of home care visits after discharge of a total of 26 visits per week. The IoRN was used on discharge from hospital and from transfer team and 6 months later. Increased carer and user satisfaction reported with services, which Pam was able to illustrate with 3 patients stories of people previously unwilling to accept care.

Evelyn described how, in the future, they hoped the programme would be sustained by:-

- Rolling out the dementia awareness training programme
- Integrating intermediate care with mainstream services and obtaining more evidence of benefits

- Have dementia champions in each acute ward
- Seek future funding for further development
- 

### **West Glasgow**      **'Small but vital steps'**

Pam noted that the West Glasgow demonstrator is one part of a number of strategic objectives and it is about making connections and integration between them work better. The objectives include providing a range of enabling rehabilitative and treatment services which promote –



- Faster recovery from illness
- Unnecessary hospital admission avoidance
- Timely hospital discharge
- Supported self care/re-ablement at home

The project has just appointed a project manager and is linking with implementation of the primary care framework and long term conditions work strands.

Key elements of the model will be supported Self Care and Re-ablement at home through:-

- Disease specific Care Management
- Re-ablement role for Formal Care Homes
- Information and training for informal Carers

### **Orkney**      **'We're peedie'**

Sylvia Campbell explained that the origins of the intermediate care service lay in the development of a CHSCP which, whilst in shadow form, was very helpful in enabling an approach across health and social care incorporating a range services into a joint management approach. At the same time, in Balfour hospital, through a number of patient audits, it was recognised that many people could undertake rehabilitation in a community setting and be at home if an intermediate care service existed.



David & Goliath

A number of beds were closed in the hospital to enable resources to transfer to support the development of a community based intermediate care service.

Team building was found to be very important in designing the service and it was really helpful to visit primary care teams across Orkney and explain the concepts and practicalities of an intermediate care service. Also useful were visits to other intermediate care services across the country. The service is now established and delivers early discharge and admission prevention, from 8-8.30 seven days a week. Key to the team are generic rehab support

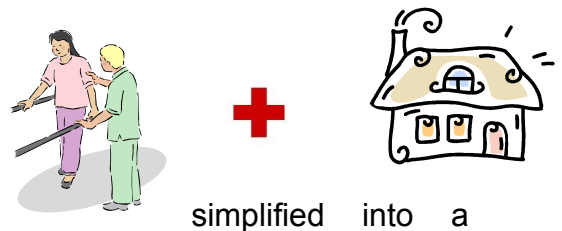
workers, integrated into the core team with qualified nursing and therapy staff, stroke workers and close working with social work.

The first 6 months formal evaluation is due at the end March. However, from a snapshot at 12 weeks it can be seen that hip and knee replacement patients have come straight back to their own home and only one has since needed home care, whereas they previously all did. In the past there were 15-20 patients in any one day in hospital who would benefit from an intermediate care service and who are now cared for at home.

Digital stories are being prepared and the many cards and letters from appreciative patients are testimony to how well the service has been received. Annie's story illustrated how even very complex and nervous patients can be admitted successfully to the service.

**Borders**      *“Enabling you ...”*

Angie Lloyd Jones and Sandra Pratt showed how, through the Intermediate Care project, very complex linkages of various services across intermediate care are being more coherent pathway.



2 Intermediate Care Demonstrator projects are underway.

The Waverley Intermediate Care Service is a wing in a care home dedicated to step up and step down care. It has been subject to a very successful evaluation which is on the JIT web site. <http://www.jitscotland.org.uk/action-areas/intermediate-care/publications/>

Currently being developed, the second IC project is based on 2 Day Hospitals – redesigning the way they work, including linkages with Dementia Scotland, the carer centre and crisis care and a different transport model responding to need and an extended working day. The transport model utilises links with the Red Cross. With buddy/drivers who play a full and vital part in the rehab programme

Angie highlighted the results and learning points of a questionnaire based study facilitated by the JIT. The key recommendations of the report supported

the Borders' proposed restructure of the overall rehabilitation services into a unified intermediate care service.

### 3. KEY THEMES FOR INTERMEDIATE CARE GUIDANCE

Participants were asked to identify the main components of Intermediate Care which would need to be covered in a guidance note and group these into key themes. They were then given one of the main headings each and asked to identify the headline areas which would need to be covered within that guidance.

Below is a summary of the components captured by each of the groups and summarised under key themes. The following section identifies the issues which were felt needed to be captured by the guidance when published – again under the same key theme headings.

#### 3.1 Themes

##### 1. *Strategic Context, Purpose and Direction. Accountability*

- How it fits with the rest of the whole system
- Link with other strategies – needs to be at forefront/priority
- Policy overload and confusion - still not joined up
- Partnership and shared vision
- Communication/IT
- Accountability
- Finance
- Quality strategies
- Demographic Change
- Terminology - Label and definition of 'Intermediate Care' (do we need it – need for clarity - means different things for different people)
- Clarity of focus with clearly defined outcomes
- Leadership - “getting on the bus” cultural change
- No national steer –
- Social marketing, messages and stories from staff, users and carers. Community belief in effectiveness. Broader awareness of strategy

##### 2. *Integrated approaches across sectors; teams and professions*

- Right mix of Multi disciplinary and specialist input – right skill set; joint protocols; integration, role and flexibility
- Partnership & collaboration. Extends way beyond LA and NHS partnerships – crucial involvement of GPs and out of hours services; service users and family carers; 3rd sector/private sector especially care homes; across acute/primary/secondary settings; supported housing; telehealth; NHS24; ambulance services;
  - Shift in balance of care requires shift in balance of power
  - Interfaces - “pass baton” at right time
  - Shared whole system communication and IT

### **3. Workforce development**

#### **Workforce**

- More generic roles - care support workers
- multifaceted and multi trained staff
- Using/recognising expertise – especially nursing
- Ability to work collaboratively/ in partnership
- Ability to work with risk and to 'sell risk' to hospital based practitioners
- Rehab – nursing roles
- Night staff levels
- Clinical support – geriatrician/rehab physicians
- Clear competencies and role description. For all disciplines/team members from generic support worker to senior clinicians – best use of time, skills according to patient's needs

#### **Skills**

- Skills audit and specification
- Education – staff/patients/carers
- Rehabilitation/reablement specialist training – rolling programme
- Family carers to be trained too
- IT literacy and availability
- Leadership
- Teamwork/building
- Sharing of skills - crossing traditional professional boundaries
- Education and training programme to help other services understand

### **4. Person centred and outcomes focussed**

- Individual need and personalisation
- Self managed and enabling
- Range of options based around individual's needs - person centred, not services driven
- Not age specific
- Incorporate principles of care management
- User focussed outcomes
- Maximising people's potential
- Confidence
- User & Carer Involvement
- Shared approaches to risk/benefit evaluation (with more appetite for risk)

## **5. Information/Data, Evaluation, Value for Money**

- Clearly defined governance (clinical and management) and performance management arrangements
- Constant evaluation/action research model (all levels)
- Equity of service
- Value for money - cost effective and sustainable. Demonstrating the added value
- Integrated resources and clear financial framework
- Direct payments (need to address anomalies across LA and NHS re charging policies)
- IT systems
- Communication
- Sharing info

## **6. Pathways and Service Delivery – access, range & scope**

### Access

- No exclusion. Not age or condition specific. teams need to recognise Mental Health issues
- Criteria?
- Self referral
- Single point of entry/contact/access
- 24/7 availability
- Timely
- Different levels of support
- Remote and rural issues
- Access must be available through various routes and referral sources, self-referral included
- Flexible system, trial discharge, in-reach/outreach
- Uncomplicated entry and discharge
- Rapid access to diagnostics for faster discharge/admission prevention

### Range and Scope

- Range of disciplines and competencies
- Range of agencies
- Can operate in all care settings – care home, home, day hospital – no ‘one size fits all’
- 24/7 - flexible
- Clear identity
- Integrated assessment

- Flexible/transitional but with clear re-entry
- All levels of support – not just direct contact – includes information, advice
- Accessible, comprehensive medical care – visible medical leadership (esp. rehab)

#### Pathways

- Tailor Intermediate care to fit in with mainstream services
- Links to anticipatory care and LTC management
- Services that support transition and deliver sustainable stay at home can provide pathways from highly specialist and very generic services (pull)
- Care home model needs to change and be more flexible - work in partnership with Care Homes to prevent admissions
- Links with wider redesign, service delivery
- Redesign and change
- Supporting people at home preventing admissions, facilitating discharge
- Flexibility around review /+recall case mgt back in to service
- Not time limited – joined up/ cyclical
- Agreed pathways and joint protocols
- Capacity and flow across acute hospital
- Complex needs assessment with diagnostics and anticipatory care, acute general assessment

### **7. *Mainstreaming and wider health and social care systems and community supports***

- Should be mainstream, joining up what we already do. Lots of different teams – needs to be joined up
- Sharing and embedding local examples of good practice
- Intermediate Care is part of and embedded within rehab/enablement approach
- Sustainability
- Aligning systems/processes
- Long term/consistent

## 3.2 AREAS FOR GUIDANCE TO ADDRESS

### **a) *Strategic Context, Purpose and Direction. Accountability***

How does Intermediate Care fit; accountability; Partnership

#### Important

- Describe overarching principles
- Be consistent and link/dovetail how strategies fit together. Cluster and link strategies
- Reflect statutory legislation
- Always reflect partnership strategic context

#### Need to know/included in guidance

- Simple diagrams and pictures
- Strategy implementation plans including any government targets, milestones expected
- Potential contribution of Intermediate Care
- How can Intermediate Care influence and deliver strategy? E.g. Intermediate Care is how we will deliver aspects of rehab framework and HEAT
- IRF is platform for delivering Intermediate Care

#### Examples

- Good practice examples would include health and social care economics
- Executive summary – case studies from demonstrations e.g. West Glasgow – HEAT; Borders – HIC; Fife, West Glasgow – Pharmacy contract

### **b) *Integrated approaches across sectors; teams and professions***

#### What Are the Sectors?

NHS, council, 3rd sector, community capacity – community planning, police, fire, partners - everyone !!!

#### What Are the Strategic Drivers?

Need to be pulled together and common themes and common purpose identified, including :

- Shifting the Balance of Care
- Quality Strategy – bridges in quality strategy
- LTC
- Kerr report
- Patient safety programme
- 20th century social work “changing lives”
- Dementia Strategy
- Better health, better care
- ICPs
- IRF
- Reshaping care

### What Does Integration Require?

Guidance needs to provide a framework based on common themes and purpose which can then lead to local interpretations/solutions that suit the context. Integration doesn't necessarily mean structural integration.

### Examples of good practice?

Some of the Intermediate Care demonstrations should reference to the strategic drivers if not explicitly linked Quality Strategy could be used as the basis for the framework.

### Guidance for practitioners

Culture shift among staff needed – a paradigm shift?!

Use talking points within the context of the wider, plethora of national initiatives SBC, reshaping ....

Expand Capability framework to be wider across sectors, teams and professions? The public will listen to clinicians so clinicians need to be on song, other colleagues need to be on song, everyone needs to have the same understanding at all levels.

## **c) Workforce development**

Core Team comprising of mixed staff

Interdisciplinary working

What skills are required – focussing on the 4 C's:-

1. Capacity
2. Competency (integration of workloads)
3. Capability
4. Communication

1,2 and 3 key to development of workforce.

Focussing resources to undertake assessment of need - ensure staff have appropriate competency.

### Key questions :-

- What is our core business?
- What do we need to deliver that business?
- Who do we need to deliver that business?
- What previous information is out there already that we can draw on – job descriptions?

Consider access to specialist services.

Consider the benefits of having the voluntary sector as part of core team

### Writing Guidance

Needs to be a reasonable size – short but as many web links as possible and cover all the sectors.

For workforce development; links to:

- Job descriptions
- Training etc etc
- Glossary at back re courses etc

### ***d) Person centred and outcomes focussed***

Guidance needs to cover:-

- Link to self directed support/personalisation
- Management of unrealistic expectations
- How to support staff to work with people
- Provision of community based services
- Tension between outcomes v eligibility criteria – fair access to care

What's important:-

- Shifting balance of control to individuals
- Changing perceptions of staff and service users/carers
- No barriers
- Carer/client conflicts
- Training on outcomes focused assessments
- Fit the services around the person not trying to fit person into existing services
- Ability of staff to refer with confidence to other services
- Professionals shouldn't impose their views on person
- Not always short term – tailored to the individual for as long as needed
- Intensity and need of individual should determine length of service (Perth & Kinross example)
- Clear exit strategies
- Continuity of service – building trust etc
- Budget for individuals (not just self directed support) to provide continuous care

### **e) Information/Data, Evaluation, Value for Money**

The guidance should be clear at outset what the success factors are – it's not about evaluating demonstrator sites, but using the evidence produced from them and clear that Intermediate Care can demonstrate outcomes. Need to provide evidence of what a good outcome is and what would success look like. As service, need to be clear what you want to deliver and develop measures around it.

Needs to include:-

Information Requirements – including data about how individuals feel and about service provision.

Key messages about:

- What Intermediate Care is there to do
- How it is already delivering good outcomes
- There is capacity to show that main thrust should be about what would you want to do for ongoing monitoring, balancing evaluation versus routine.
- Reviews of patients (3,6 months)

Valid and robust tools need to be identified, including:-

- Common core dataset.
- Supplementary data : access to EA
- Real-time data
- Guidance and support on how to do it.
- 3/6 month reviews.
- JIT Guidance welcomed
- Balance of central versus local information provision
- A way of tracking hand-offs through pathways
- Access to robust/real time national data (ISD)
- Following/tracking – toolbox of possible things that would be beneficial to use.
- Preamblement Teams – need to be part of evaluations...

### **f) Pathways and Service Delivery – access, range & scope**

Guidance needs to identify principles, eg:-

- Accountability
- Timely
- Anticipatory
- Discharge
- Matrix – different entry points; Acute/rehab entry points and from continuing care
- Consistent approach therefore knowledge base at 'admission; discharge'

Different pathways but set of principles regardless of where :-

- Assessment

- Most appropriate person
- Personalised plans
- Keeping people at home
- Communities supporting themselves
- Localised
- Able to be revisited
- Lots of consultation/discussion
- Agreed, shared goals
- Audit against shifting balance of care - beds reduced; community service increased
- Joint agreement on outcomes
- Consistent point of contact/roles, expanding out of hours
- information support
- seven day service
- predictable
- scheduled/unscheduled
- local demand modelled
- telehealth
- single point of contact and localisation
- social care response

***g) Mainstream and wider health and social care systems and community supports (NHS, LA and Vol Sector)***

Guidance needs to cover the following areas :-

- standard definition to work to
- education
- awareness raising and publicity
- understandable roles
- onward referral
  - criteria – each transfer point
  - clear pathway
  - understanding aims and value
  - understanding of outcomes aiming for
  - maintain and upskill mainstream services
- developing 7 day service across primary and secondary care, LA care as well as voluntary sector
- require clear discharge plan and date overall
- information goes with the person, supportive documentation/IM&T systems across agencies and services
- Voluntary sector must be fully integrated and core to delivery
- Understand their skills and service they can offer
- Must be appropriately supported and resourced
- Housing – different models
- Telehealthcare solutions

- Carers – support, education
- Clinical leadership with authority to direct
- Strategic leadership
- Organisations must give permission to services to change

## ***h) Leadership and Culture Change to Make it Happen***

### **1. Shift focus from eligibility focus**

Be brave and be clear about –purpose, principles and approach.

Get to a point where lose ‘spin’ through honesty and unleash staff innovation.

Trust leads to engagement.

“It all starts with the patient” – at a patient level solutions are simple if staff have permission to pursue them.

### **2. There has never been a better climate for doing this at a quicker pace**

We need to address the following:

- Devolving leadership to operational levels
- Identifying influencers and get them on board to be champions/activists
- Invest in time to nurture partnership working/dialogue – understand each others issues/priorities
- Understand how both sides work
- Balance between corporacy v localism
- Test and spread your approach
- Give staff your support and empowerment
- ‘let go’
- Keep it simple and it doesn’t need to be perfect
- Use stories and personalise to connect to hearts and minds
- Shift to a continuous improvement approach rather than the perfect gold standard.
- Know what’s important to service user
  - Reliability
  - predictability
- Keep listening to user views
- What about the name – does it matter? ‘Google test’ for what it is called
- New respect for independent sector role as leaders and champions too
- Opportunities though IRF – transparency of decisions
- Public accountability
- Engage and harness community and voluntary sector

## 4 CONCLUSION

Margaret Whoriskey closed the day by recapping on next steps:-

- This report from the day will be published during April 2010 and the link will be distributed to all delegates from the event.
- She drew attention to 2 key events which are programmed very soon:-
  - NES/JIT Intermediate Care Capability Framework Launch on 19<sup>th</sup> May
  - The consultation on self directed support
- Intermediate care demonstrators will be asked to submit final or interim reports.
- From the work started today, an Intermediate Care Guidance document for Scotland will be drafted. The process for this will be shared once plans have been agreed.
- Alex Davidson was then invited to provide an outline of the JIT reablement workshops which are being offered to partnerships. These workshops aim to provide a framework and basis for developing reablement services across Scotland. Everyone was encouraged to look out for workshops in their locality.
- Margaret then thanked everyone for their attendance at the event and the day was closed

March 2010