



**JOINT IMPROVEMENT TEAM
INTERMEDIATE CARE LEARNING NETWORK**
—
SHARED LEARNING AND DEVELOPMENT EVENT

Solutions in Housing and Care

17 April 2008

1. Introduction

The Joint Improvement Team has established a national Intermediate Care Learning Network to support shared learning across health and social care services in Scotland.

The JIT Intermediate Care Learning Network, in association with housing providers, care providers, social services and NHS partners organised a shared learning event to support health, social care and housing partnerships develop intermediate care services in a range of housing, care home and community hospital settings.

The event aimed to:

- Explore models of intermediate care in local authority and independent care homes, in housing and in community hospital settings.
- Provide an update on relevant intermediate care schemes currently available within partnerships
- Provide an opportunity for partnerships to discuss future developments.

The programme was introduced by Judy Gibson, JIT Associate, who gave an overview of the intermediate care learning network. Five partnerships presented examples of intermediate care delivered in a range of settings: within an independent care home in Angus; in sheltered housing in West Dunbartonshire; in a community hospital in South Lanarkshire; within sheltered housing in Fife; and in two local authority care homes in North Lanarkshire.

Representatives from Scottish Care, the Care Commission and the Scottish Association of Community Hospitals outlined the role of their organisations in supporting developments in intermediate care. This session included a panel question and answer discussion with delegates.

Four workshop groups participated in facilitated discussion on future developments. Digital stories illustrated the service user experience and perspective of Intermediate care. The day ended with a session which captured key lessons from the day.

2. Key Themes from the Presentations

2.1 JIT Intermediate Care Learning Network and context for Intermediate Care

Judy Gibson JIT Associate

2.1.1 Context

A shared definition of intermediate care is contained in the Joint Improvement Team's 'Intermediate Care' Scoping Report 2007 (www.jitscotland.org.uk). The following definitions from England translate well to the context of Partnership working in Scotland.

“Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. This includes:

- *Intermediate care which substitutes for elements of hospital care (substitutional care); and*
- *Intermediate care which integrates a variety of services for people whose health care needs are complex and in transition. (complex care)”*

(Oxford and Anglia Intermediate Care Project, 1997)

“A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care”.

(Making Connections, Change Agent Team, 2006)

Intermediate Care Services can be provided in:

Individual's own homes, sheltered housing and very sheltered housing
Day Hospitals, Day care centres and integrated day services
Designated beds in care homes
Community Hospitals

Intermediate Care Services aim to have the following outcomes:

- Supporting more people at home
- Reduced time in hospital
- Increased independence
- Improved quality of care
- Reduced admission to residential / nursing home care
- Faster access to some services
- Shift in care from acute to community settings
- Increased provision of local services

2.2 Independent Care Home Model

Phillip Gillespie & Susan Andrews, Angus partnership

2.2.1 Very Sheltered Housing and Care Home

Intermediate care services are being provided in a range of settings in Angus including:

- a) Intermediate care in individuals own homes – e.g. Early Supported Discharge
- b) Independent Intermediate Care in Very sheltered housing and in an Independent sector care home

Independent Intermediate Care is delivered in two models:

1. 6 commissioned beds for step up-step down care in an independent care home. Criteria for access:
 - 60 years or over
 - Identified rehabilitation needs unable to be met through early supported discharge/prevention of admission services
 - Short term support, assessment & rehab

Criteria for access for enhanced respite:

- 60 years or over
- Support for carers
- Care provision for up to 2 weeks

In-reach occupational therapy and physiotherapy are provided from the CHP for up to 4 weeks for “step up-step down” care or for two weeks for enhanced respite. Access to these beds is managed by the Early Supported Discharge co-ordinator and weekly reviews are linked to the care management process. The team has established links with the Telecare programme and the local Community Mental Health Team. An average of 75% of people managed through this facility returned to live at home following their period of intermediate care.

2. The Angus service has recently extended independent intermediate care to a flat within a very sheltered housing complex. A flat has been leased for 6 months for the purpose of Intermediate Care. The service user has access to 24 hour social care, inreach AHP, District Nursing and care management support for up to 28 days. The flat is fitted with a range of Telecare equipment.

There was a discussion regarding further development of this model exploring issues such as who is most suited to the intermediate care flat? Is it located in the most appropriate place? Is AHP capacity at optimum?

2.3 Sheltered Housing in West Dunbartonshire

Richard Heard

Richard provided an outline of sheltered housing services in West Dunbartonshire and highlighted some interesting learning on the importance of language to service users, e.g. the name “Warden” has been replaced with “supervisor” following feedback from residents.

He described the various partners who contribute to care and support in sheltered housing and their successful integration as a single generic team across housing support and home care. Training needs addressed included dementia awareness and health improvement such as ‘movin about’.

Five furnished flats in Clydebank & Dunbartonshire offer a step up-step down service similar to Angus. They have been upgraded in recent years and are supported by local rehabilitation and support services including IRIS and Rapid response Teams in addition to 24 hour response services. A standard Telecare package is installed in all flats and this can be enhanced with falls detection, bed or movement sensors according to individual needs. Criteria include a maximum length of stay of 12 weeks, achieved through successful integrated working with housing partners. Outcomes indicate that 50% of residents have transferred to a permanent sheltered housing location or returned home following their stay.

2.4 Community Hospital, Clydesdale

Fiona Andrews

Three community hospitals in rural settings in Clydesdale provide a total of 14 rehabilitation beds for intermediate care. Access criteria includes need for ongoing rehab, expected improvement in function, clinically stable, able to transfer with help of one, patient & family agree to transfer to the community hospital and the patient is registered with a local GP.

The intermediate care beds are integrated with other rehab beds in the hospital and the services of OT, Physiotherapy, GP, Speech & language therapy, dietician and others are coordinated through a rehab coordinator for the service. The therapists follow the patient journey to work on extended ADL and mobility at home.

The majority of patients (72%) managed through the service go home, approximately half of these with a package of homecare. Average length of stay for Intermediate care in the three sites ranges from 23 – 36 days.

Fiona highlighted a number of challenges for the service including delineation of the service from mainstream services, changing historical expectations of the local community and responding to the needs of the growing older population.

2.5 Scottish Care

Ranald Mair & Ian Buchan

Ranald and Ian suggested Intermediate care could be a new role for care homes which are increasingly diversifying to provide a range of care services.

Of the 950 care homes in Scotland, 70% provide nursing support. 650 care homes are members of the umbrella organisation Scottish Care. Care home sector staff are employed by the independent sector (76%), local authority (14%) and voluntary sector providers (10%).

Ian suggested the decision regarding place of rehabilitation care is currently based on “what clinicians can access” rather than what is actually required by the individual. They pointed out that most of the focus on care homes for Intermediate care is in a step down role. He challenged the audience to consider their role in prevention or step up care and their potential to support long term conditions management.

To move the agenda forward the following recommendations were made:

1. Draw on examples which are already there
2. Make sure we explore and evaluate new models and opportunities,
3. Develop leadership within the care home sector
4. Work as a whole system, including the independent and voluntary sector partners

2.6 Care Commission

Marcia Ramsay

Marcia outlined the role of the care commission and urged delegates to take away the CD which provided more details on their role in registration, inspection, complaints and enforcement. She referred to the 23 sets of National Care Standards, including several which relate indirectly to Intermediate Care in terms of care services, housing support services and adult placement.

The care commission is keen to support innovation in the sector and encourages partnership and early engagement with providers and commissioners. Key steps are:

- Communication – if in doubt about need to engage with care commission, ask.
- Describe your service in a service outline.
- Consider what regulation is likely to be required and seek advice if unsure.
- Changing or adding to an existing service already regulated is possible. We were reminded to consult with all stakeholders, including care commission, regarding changes to a service.

2.3 Community Hospitals Association

Dr Hamish Greig

Hamish provided a full outline of the Scottish Association of Community Hospitals. There are currently 71 community hospitals in Scotland – with new ones emerging. The majority are in rural settings and have a bed base but there are growing numbers of urban models, e.g. in Inverness, Aberdeen and Lothian.

Many of our community hospitals have been well established for a long number of years and the distribution of them is variable across partnership areas often due to local influences. Many were established by local communities following the First World War.

Communities are often very protective of their local hospitals and emerging proposals for a changing role for their hospital will be a challenge for many local communities. This needs a programme of education, support and engagement including a clear statement about the drivers and benefits.

The future role of the community hospital is outlined in the community hospitals strategy and it is clear that the development potential for these are wide and varied. Drivers include shifting the balance of care from secondary care into the community, enhancing community based rehabilitation, improving the management of long term conditions will secure the future role of these institutions in the coming years.

2.8 Panel Session

All of the guest speakers returned to the platform for an interactive panel session facilitated by Dr Anne Hendry A summary of the Q&A is presented

- Q.** *What are the implications/solutions for the removal of 24 hour on site wardens in sheltered housing?*
- A.** Access to overnight support is built into care packages through the community alarm service and has not created a problem in the West Dunbartonshire model.
- Q.** *Where can we find suitable and validated evaluation tools for measuring the success of the new models that we are developing? Need to clarify what we evaluate and create a baseline for measuring against.*
- A.** Client outcomes can be used. We need to develop new evaluation tools – this is a development need. There is a lot of work ongoing on cost cube – this may be a starting point for the development of evaluation tools. Using your own service baseline as a starting point. A self assessment provides a good description for a service to measure against.
- Q.** *There are differences in duration of intermediate care intervention. Do we need agreement on a set maximum time for intermediate care intervention?*
- A.** One size will never fit all, but we should consider putting on some time frames whilst retaining flexibility.

- Q.** *Increasing challenge in managing the expectations of service users, in particular the changing function of community hospitals. How do we manage this effectively?*
- A.** People want to be close to home, particularly at end of life and when they are on a recovery pathway. We must ensure we communicate the benefits of expanding the role of the hospitals to support users needs. We need to give confidence to service users in the quality and standards of care we can offer in localities and the care commission's self assessment grading against thematic areas was highlighted as one formal method.
- Q.** *Quality & timeliness – How do we ensure availability when Intermediate care is required?*
- A.** This is challenging if we are to ensure maximum use of resources. Flexibility and ensuring we keep people moving through their pathways of care in all parts of the system. Contingency planning was also highlighted as important consideration for services.
- Q.** *How can we ensure that services available are fully utilised across partnership areas?*
- A.** Important to do good capacity planning locally. Neighbouring partnerships should be in contact with each other to ensure maximum use of available resources. There is concern that this problem may become more prevalent. It emphasises the issue about whole system working and the need for high levels of communication across the system.

2.9 Housing in Fife

Anne McAlpine & Gwyneth Thom

Anne and Gwyneth outlined a community based model of Intermediate care in a sheltered housing complex in Dunfermline. Three sheltered housing units are supported by inreach from community based rehabilitation services, integrated response teams based in the community and a day time warden. Overnight support is accessed through the community alarm service.

The criteria for access include all adults registered with a local GP in West Fife. Referrals are filtered through the Point of Access for Community Teams (PACT). Residents are not required to pay for the service, but must finance their own shopping.

Finding the right client group for the service is still challenging the team delivering the service and requires further scoping. The service, which is still relatively new, has found the logistics of joint working difficult on occasion with simple but essential elements of the service being difficult to deliver due to unclear lines of responsibility.

2.10 Local Authority Care – North Lanarkshire

Karen Malone

This is a new service which has only been running since November 2007. It operates across two local authority care homes in adjacent townships in North Lanarkshire. The resourcing of the new service was found through surplus capacity in residential care and redesign of a rapid response service. The service offers both upstream and downstream rehabilitation through inreach by the local rapid response and supported discharge service, complemented by an enablement approach maintained by the care home staff. An awareness of a rise in emergency placement in care homes for respite led to the decision to target this group with the aim of enabling people to reach their maximum potential with support and rehab in a residential setting.

The service was initially established for a period of six months but it is anticipated that this will extend and that developments in increasing community referrals to the service will be phased in over the next few months. A more formal evaluation of the outcomes of the service will also be delivered later this year

3. Workshops

Six facilitated groups met for an hour's discussion.

All workshops groups received the same outline briefing to address the following:

- Discussion on the definition of intermediate care
- Reflections of the spectrum of intermediate care in care, housing and community hospital.
- User issues for these new models of care
- Local solutions identified by delegates
- Identify other examples of good practice

3.1 Feedback from the Workshop Groups

3.1.1 Definition of Intermediate Care

A number of issues were raised regarding the definition. These included the following: Intermediate care is part of a care continuum and facilitates a focus on one part of the pathway of care.

- Should intermediate care include all medical services that don't need acute care?
- Labelling as intermediate care can be a constraint, but defining helps with assessment and evaluation
- Local partnerships need to agree on their local definition and shared understanding to enable service planning.
- All services should focus on achieving agreed indicators, single outcomes objectives/targets, rather than worrying about "labelling" service teams.
- There would be a benefit to have a national criteria which can be interpreted locally – ensuring partnerships translate this into what is right for their locality.
- Intermediate care has become a new way of working – not a new service.
- Duration of intermediate care depends on a number of factors and insistence on a time limit is not necessarily beneficial to patient outcomes

The groups then spent time reflecting on the different housing, care and community hospital models of intermediate care presented throughout the day.

3.1.2 Housing

- Concern was raised about the effect on housing benefit if people were placed in an intermediate care facility for over 28 days.
- There was much debate about the target client group for this model of care. This included questions regarding why someone should be moved to a housing model when remaining / returning home with support is in general preferable and in most cases a better option.

- At home is usually preferable, but if not possible the housing option should be in the persons local community.
- Intermediate care initiatives are generally tied to housing voids – clients are potentially being placed in the least popular of available units.
- Each service area has a different service mix; this affects ongoing care after the intermediate care phase.
- Occupational therapy assessment and treatment should preferably always be carried out in a persons own home rather than in a short term setting.
- In some areas there are links to housing associations, others are independent.
- Charging practices are variable across the partnerships.

3.1.3 Local Authority Care Homes

It was noted that not all partnerships have local authority care home provision. However, for areas with capacity the following reflections were noted:

- This model provides opportunities for rehabilitation outside a medical setting.
- Using intermediate care in care homes as a “step up” was seen as a better option than an unnecessary hospital admission for people who require a period of care outwith home.
- A care home provides a more homely environment than a hospital.
- Intermediate care requires staff to develop different skills to ensure an enablement ethos.
- Changing the public’s perception of care homes as end of life care will be required for success.

3.1.4 Independent Care Homes

Some issues were similar to those for local authority care homes. These included public misconceptions, workforce skills and limited capacity in some areas. Other issues for independent intermediate care were:

- Moving from bed to block purchasing reduces flexibility and accessibility of places.
- Charging policies are variable creating inequity for the users. The NHS policy of free at the point of delivery means places purchased through NHS are free whilst Local authority places are not.
- We need access 24/7 to ensure equitable access out of hours particularly for step up.
- We require staff with rehabilitation / enablement skills in addition to the established care home workforce

3.1.5 Community Hospitals

It was noted that where models have worked there has been good local support across the system.

- A number of concerns were raised regarding the constraints on changing the use of beds in community hospitals. In particular the medical model in community hospitals can be a constraint to alternative ways of working. Also the relationship between GPs and management can influence ability to develop services.
- There are opportunities for developing technology to deliver solutions within community hospitals – eg tele-health.
- The needs of younger people were highlighted and their use of community hospitals is an area not well developed.
- The workforce has to have the skills to deliver effective intermediate care services, so there are trainings needs for staff in most locations.

3.1.6 User Issues

A variety of points were made by the groups and these included:

- Quality and flexibility within services are both important to users.
- Charging policy variations are unhelpful and confusing to users. This includes the philosophy of NHS services being free at the point of delivery while social services and housing have charging policies.
- Younger people's needs are not currently always addressed
- People do not want to be in institutions at all or if they must, any longer than is necessary.
- There is concern about people having to make life changing decisions whilst residing in settings which are neither enabling nor appropriate.
- Historical perceptions of staff and users are not always in step with planning and redesign.

Some of the potential solutions noted by the groups included:

- Establishing joint commissioning and joint funding. The need for real joint budgets is growing.
- Improvements in partnership working to reduce "red tape" for users.
- Communication with users still needs to get better
- Initiatives to enable people to be in more appropriate settings when making life changing decisions should be encouraged
- Communication and engagement with "grass roots" staff will reap benefits. Staff on the ground manages very well with changes, once they have experience.
- The needs of younger people need to be more explicitly included in planning.
- Personalisation agenda requires streamlining across all sectors.

3.1.7 Local Solutions & Examples of Good practice

Unfortunately most groups were short of time at this point in the day and did not fully explore this part of the task. The following comments were submitted by the groups who did have time to discuss:

- Old Age Psychiatrist/Geriatrician following up people post discharge, ensuring any residual medical problems are addressed appropriately.
- In Glasgow electronic links between the GP practice and care homes have been established.
- Angus & Moray both described examples of practice where decisions regarding long term placement in institutional care are made outwith acute care. People are transferred home with a package of care, or to a community hospital / intermediate care setting to assess longer term support needs and options.

4. Summary and next steps

A number of key themes and issues emerged from the day and the following topics clearly require further debate, scoping and action:

- JIT plans to scope the opportunities within the policy context for intermediate care across health & social care in Scotland
- JIT will work with partnerships to support the development of models of evaluation of intermediate care services. This will include further consideration of alignment of the right client to the right resources
- The JIT capacity for change programme can be used to assist joint capacity planning and commissioning of intermediate care services. (<http://www.jitscotland.org.uk/knowledge-bank/toolkits/capacity-to-change.html>)
- Partnerships are encouraged to provide information on their services, including evaluation methods and outcomes alongside examples of good practice. JIT will share this information through the network and on the website.