



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

**Building the Capability to Deliver Effective Intermediate Care**

**13 December 2007**

## **1. Introduction**

The Joint Improvement Team established a national Intermediate Care Learning Network to support shared learning across health and social care services in Scotland. Training and education have been highlighted as priorities at previous workshop events in June and September 2007.

The JIT Intermediate Care Learning Network, in association with NHS Education for Scotland (NES), Scottish Social Services Council, Stirling Dementia Services Development Centre, Alliance for Self Care Research and local partnerships, organised a Shared Learning event to support Health and Social Care Partnerships in up-skilling their workforces to deliver their intermediate care developments.

The event aimed to:

- Provide a brief overview of Intermediate Care services in Scotland and the role of the JIT learning network;
- Provide an overview of relevant training currently available to staff across partnerships;
- Share the plans in health and social care for development of training and education;
- Showcase examples of successful local staff development;
- Provide an opportunity for partnerships to highlight learning needs and skills gaps and explore ways of addressing these.

The event attracted interest across Scotland with participants from health, social care services and other organisations, including voluntary sector. The majority of participants were from social services.

The programme included an overview from JIT and an update about relevant NES and Scottish Social Services Council programmes. There followed a joint presentation from North Lanarkshire and Glasgow Caledonian University, an introduction to the Dementia Services Development Centre resources and information about the Alliance for Self Care Research.

The presentations were followed by a workshop session to discuss a draft Multi-agency capability framework for intermediate care. This had been developed in Lanarkshire through a project funded by NES West region. Working groups discussed the 7 domains contained within the draft framework.

## 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

Judy Gibson outlined the context for intermediate care, key drivers for health and social care partnership working, and highlighted the new National Outcomes Framework for community care services, being implemented from 2007/2008.

There are 4 high level outcomes:

- improved health;
- improved wellbeing;
- improved social inclusion; and
- improved independence and responsibility.

These high level outcomes have 16 measures (Table 1):

**Table 1**  
**National Outcome Measures**

<ol style="list-style-type: none"> <li>1. % of community care service users feeling safe.</li> <li>2. % of users and carers satisfied with care package.</li> <li>3. % of users satisfied with opportunities or social interaction.</li> <li>4. % of user assessment completed to national standard.</li> <li>5. % of carers' assessments completed to national standard.</li> <li>6. % of people 65+ with intensive needs receiving care at home.</li> <li>7. % of people 65+ receiving personal care at home.</li> <li>8. % of carers who feel able to continue their role.</li> <li>9. Shift in balance of care from institutional to 'home based' care.</li> <li>10. No. of patients waiting more than 6 weeks for discharge to appropriate setting.</li> <li>11. % of care plans reviewed within agreed timescale.</li> <li>12. No. of people waiting longer than target for assessment, per 000 population.</li> <li>13. No. of people waiting longer than target time for service, per 000 population.</li> <li>14. No. of emergency bed days in acute specialties for people 65+, per 100,000 population.</li> <li>15. No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000 population.</li> <li>16. No. of people 65+ admitted twice or more as an emergency who have not had an assessment, per 100,000 population.</li> </ol>
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These measures incorporate existing targets relating to delayed discharge, repeat emergency admissions and provision of home care services. Achieving a good

balance of care will require appropriate and effective ‘step up’ and ‘step down’ services (intermediate care) and access to the full range of rehabilitation services to maximise independence and optimise function.

## 2.1.2 Intermediate Care Services in Scotland

A shared definition of intermediate care is contained in the Joint Improvement Team’s ‘Intermediate Care’ Scoping Report 2007<sup>1</sup>. 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)

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.

and include:

Rapid response services/supported discharge teams;  
Intensive care at home schemes;  
Extra care housing/telecare initiatives;  
Innovative use of community hospitals;  
Community assessment and treatment teams.

Intermediate Care Services aim to have the following outcomes:

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<sup>1</sup> <http://www.jitscotland.org.uk/action-areas/themes/care.html>

- 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 NHS Education for Scotland

Helen McFarlane, Programme Director

Helen provided an overview of the role of NES whereby it aims to design, commission and assure education where appropriate and to provide educational solutions for workforce development to ensure high quality patient care.

### NES Strategic Framework

1. Building workforce capacity
2. Providing educational support for national clinical priorities
3. Developing educational infrastructure
4. Strengthening partnership working.

### Intermediate Care

A recent literature search yielded limited evidence of education on Intermediate Care. Therefore NES had commissioned NHS Lanarkshire to undertake the project which is described in this report. Helen reflected that there is a degree of overlap with NES' ongoing work on Long Term Conditions, led by Sonya Lam, and with the following related work streams:

- Role Development
  - Physician assistant's pilot.
  - Review of nursing in community educational needs.
- Rehabilitation Framework
  - Scoping educational needs in Vocational Rehabilitation.
  - Developing the Rehabilitation Managed Knowledge Network.
  - Patient and carer focus for information e-library.
- Assistant/Associate Practitioners
  - HNC AHP's – Maximising skills of support staff - theoretical course for support workers. OT/Physiotherapy available autumn 2008.
  - Focus on education for Level 3 and Level 4 career framework.

- Workforce Planning and Service Redesign
  - Skills maximization toolkit is now available along with a facilitator's handbook.
- Partnership Working
  - Get going together – Induction tool for Health & Social Care Integrated Services.
  - LTC and self care focus
  - Together we can: Working with people with Learning Disabilities.
- National Clinical Priorities
  - Individuals with stroke – STARS – circulated booklets.
  - Mapping competencies.
  - Cancer capabilities framework.

### 2.3 Scottish Social Services Council – SSSC

Wendy Johnston, Project Officer

Wendy Johnston gave an overview of the SSSC and the function of the organisation. The council:

- Maintains a register of key groups of social service workers;
- Publishes codes of practice for social care, social work and housing support employers and employees;
- Promotes education and training.

The council works very closely with departments in the Scottish Government. She noted that where previously social services had been the main commissioner of services, there has been a move to a balance of 40% Local authority and 60% independent provision through voluntary and private providers.

There are diverse roles, responsibilities and qualifications within Social Services. The council is introducing a qualification based register (SSE) and is currently developing registration for managers in housing support.

Skills for Care and Development – Linking closely with Skills for Health organisations, they aim to prioritise developments in areas where skills shortages are evident.

“National Occupational Standards for Sensory Services” are also being developed.

A range of learning tools are available and include web based tools and MP3's amongst other more traditional methods of learning.

The Council is trying to develop tools which support smaller organisations as well as larger authorities. It has established a Voluntary Sector Social Services Workforce Unit (VSSWU).

The Council promotes the Scottish Credit and qualification framework, recognises prior learning and aims to maximise opportunities for employees to evidence their learning. The focus is on up-skilling the workforce and at the same time increasing job satisfaction for employees. The overall aim is to nurture a culture of collaborative learning in organisations.

## 2.4 North Lanarkshire Partnership and Glasgow Caledonian University

Rose Letham, Pete Glover & Emily Chesnet

This presentation highlighted the opportunity to work with Higher Education Institutions and student groups to prepare the future generation of integrated teams for working in a multi-professional and multi-agency basis.

### Practice Education Facilitator (PEF) Programme

This is a three year NES funded initiative to support local staff in training student AHPs so they are 'ready to hit the ground running' when they qualify.

Students increasingly have an opportunity to experience Intermediate care. However placements in Intermediate Care were previously uni-disciplinary, with the student exclusively attached to the supervising professional. The Lanarkshire team described their new approach which had been developed in partnership with HEIs and their local PEF. This new initiative enables the student to have a more holistic experience of the MDT on placement. The approach begins with preparation for placement which includes:

- Pre-placement information pack – practical information about the MDT, its operational policy and some background on Intermediate care.
- Student pack – locally held, detailed information on each discipline and roles etc.
- Learning Experiences – Still evolving. These will be a balance of generic and profession specific learning experiences.

Having students from different disciplines attached to the MDT at the same time helps promote interdisciplinary learning. Students can work together on case studies and tutorials, provide peer support and exchange views through structured reflection.

The team are developing an evaluation form. Feedback from students will further refine their approach.

An ongoing challenge is to ensure adequate time for preparation by supervisors and students and ensuring ownership by the full MDT, including a commitment to create capacity for training by balancing educational supervision and clinical caseload

pressures. Support from HEI's is in place in principle, but there are still challenges in establishing relationships and building trust in the model across all professional groups.

## 2.5 Dementia Services Development Centre, Stirling

Alan Chapman, Assistant Director

Alan Chapman gave an overview of the development centre as a centre for excellence with a specific focus on dementia. The centre works with all care providers and has a focus on best practice. He highlighted useful resources including:

- Library and Information Service
  - Research and Consultancy – Design and reformatting of buildings in care settings.
  - Publications – Research reports, books, CD's – e.g. “Franks Friday”
  - Expertise in design and technology.
  
- Education and Training Service
  - Training is available at undergraduate and post graduate level and as University accredited distance and e-learning. The training challenges traditional thinking that ‘people with dementia can’t do very much’. The department has 10 associates who develop workplace training programmes tailored to employer and worker needs.
  - The centre can supply resource materials for local use.
  
- Person Centred Care
  - The challenged for all of us is to think about what person centred care means in practice and how can we avoid disempowering people with dementia.
  - The centre focuses on developing services with an ethos which will:
    - See the individual first.
    - Be informed by their life story.
    - Implement person centred values.

## 2.6 Promoting Enablement and Self Care

Sally Wyke, Alliance for Self Care Research, Stirling University

The alliance supports capacity and capability for research on self care. It promotes participation in research by a range of professionals including nurses, midwives, AHPs, and social services. Sally is based at Stirling University and collaborates with colleagues engaged with the work of the Alliance across Scotland.<sup>2</sup>

Self care was described as what each person does while living their life with a long term condition. Sally described Wagner’s Chronic Care model and the place of Self Management within that model. Self management support does not occur in isolation.

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<sup>2</sup> For more, see [www.ascr.ac.uk](http://www.ascr.ac.uk)

The whole system is involved in supporting and enabling self care. Patients and carers should be respected as co-producers of health, supported by health care professionals. Self care is shifting the focus of care from the NHS to families and communities.

Current thinking is often based on a Deficit Model which assumes people:

- Don't self manage
- Have an ability to be taught
- Will be supported by voluntary sector organisations.

Sally challenged these assumptions and outlined what people actually do in self care when managing a long term condition:

- **Illness Work** - they manage their symptoms and medicines
- **Every Day Life Work** – they manage their daily tasks, paid work, caregiver roles
- **Sense of Self** – they manage the impact of the condition on self and sense of self.

Sally recommended the website [www.dipex.org](http://www.dipex.org) and played a video extract.

Research says it is “impossible not to manage one’s health”.

### Important Questions for Intermediate Care Teams

Whose goals are we addressing? How do we frame these? Sally illustrated this with a goal setting scenario

<b>Clinician's goals</b>	<b>Patient's goals</b>
▪ Symptom management	▪ Self management
▪ Warfarin control	▪ Feeling well
▪ BP control	▪ Doing things
▪ Blood glucose level	▪ Monitoring self

### **3. Workshops**

Trudi Marshall presented an overview of the Lanarkshire / NES West Region Intermediate Care educational project.

In July 2006 NHS Lanarkshire secured funding from NHS Education for Scotland for a four-year project to focus on intermediate care services. One of the main aims of this project is to develop and implement an inter-professional and interagency capability framework which will support practitioners working in multidisciplinary health and social care teams across acute and community settings.

This Capability Framework attempts to reflect the scope of work undertaken by multi-agency staff across health and social care services to focus upon key capabilities required by all staff groups. The current version has been revised following internal multi-agency and multi disciplinary consultation within Lanarkshire, the NES Project Steering Group, and some key individuals and groups with specific expertise.

The Capability Framework should be viewed as a generic document that can be used by multi-agency and multidisciplinary staff working within different organisations. It therefore does not contain references to any 'single system' processes (such as the NHS Knowledge and Skills Framework).

National consultation will commence in January with responses analysed and the document revised accordingly with the final document being available in May 2008. The Capability Framework will be piloted thereafter within Lanarkshire and following external evaluation will be further piloted externally in January 2009.

Seven facilitated groups considered the draft Multi-Agency Capability Framework, Supporting Staff Working across Intermediate Care Services. The workshop groups each focused on one domain. The discussions and recommendations are summarised below.

#### **3.1 Feedback from the Workshop Groups**

##### **3.1.1 Domain 1 - Knowledge for Practice**

*The health & social care worker continually updates their knowledge of new policy and research evidence relevant to intermediate care services and uses this to promote and develop effective evidence based care.*

The group was concerned that support workers may find accessing research evidence difficult in some instances. They raised the importance of promoting access to further learning for support staff including SVQ, HNC and other similar training opportunities.

They noted that all aspects of the domain were relevant to staff. Pyramid learning models were thought to be useful for developing skills in this domain.

Good practice example – Social work staff in Lanarkshire teams are being trained by speech therapy in swallowing and communication difficulties.

### **3.1.2 Domain 2 - Holistic Assessment**

*The health and social care worker uses their judgment and knowledge to assess the holistic needs of people and their carers who are using intermediate care services and to provide and evaluate evidence based care.*

The skills to undertake holistic assessment by all levels of staff were considered. The group felt that different levels of attainment in this domain should be relevant for different levels of staff. All aspects of the domain were considered important.

The use of monitoring through individual personal development and links to KSF and job families were thought to be useful ways of enabling progress in this domain.

Good practice example – single shared assessment, where available and working electronically.

### **3.1.3 Domain 3 – The Multi Agency Approach**

*The health and social care worker actively contributes to a team approach within the multi-agency context to ensure effective communication, continuity and consistency of patient and care focused care across settings.*

It is recognized that different members of the team will require different levels of communication dependant on their role in the team. All aspects of the domain were accepted.

### **3.1.4 Domain 4 – Practicing Ethically**

*The health and social care worker continually develops their knowledge of culture, diversity, ethical professional and legal frameworks and uses this knowledge to support purposeful and effective interactions with people and their carers who are using intermediate care services.*

The group was happy with all aspects of the domain and reflected on the need to develop clearer ways of establishing the differences between an individual and their carer/families wishes and goals. Further equality and diversity training was considered to be important for supporting staff in this aspect.

Progressing the domain effectively will benefit from generic approaches to the subject of equality and diversity with clear support mechanisms for staff who are working across this area.

Good Practice Example – an example where a foreign national worker, recognising that their visual appearance frightened an individual with a previous experience as a prisoner of war, requested withdrawal from this patient's care.

### **3.1.5 Domain 5 – Care and Intervention**

*The health and social care worker recognizes that rehabilitation is relevant throughout the patient pathway and contributes to rehabilitation and follow up planning for people using intermediate care service and their carers.*

The group considered that additional learning needs would include ability of practitioners to reflect and to have a sense of self. The group thought that sense of self and ability to take risks were both important aspects of the domain. They challenged the inclusion of bereavement culture and beliefs as wholly relevant to this domain.

For continuous learning the group noted the opportunities from the SSSC/Institute for research and innovation in social services and the linkages to the national occupational standards, personal capabilities and qualifications. They also felt the knowledge and skills framework could be beneficial in developing this domain.

### **3.1.6 Domain 6 – Spiritual and Religious Care**

*The health and social care worker continually develops their knowledge and understanding of the beliefs and practices of different faith/belief groups and how they might impact on the receipt and delivery of intermediate care.*

The group expressed concern around the scope of workers to address this domain and questioned their role in relation to that of a priest, minister or other religious lead.

Whilst the group agreed with the content of the domain they considered skills in active listening to help patients and carers identify key fears, concerns, hopes and aspirations in fulfilment of their lives and the ability to be reflective and to grow self awareness to be important for all domains – not only to this one.

### **3.1.7 Domain 7 – Mental Health and Wellbeing**

*The health and social care worker recognizes that mental health is a crucial component of overall health and wellbeing and actively facilitates and promotes healthy living.*

Additional learning needs identified for this domain include manual handling, awareness of evidence based practice and crisis management skills.

The group agreed that progress in achieving the domain would be improved by self assessment, peer support, involvement of HEIs and genuine engagement of the individual practitioners. They also noted that some generic profession competencies should be recognized.

Good Practice – contrary to individual staff feelings – who often view admission as failure - a well planned admission (minimising emergency services) during a crisis can be a positive outcome for the patient and their carer. This type of example requires greater recognition.

#### **4. Summary and next steps**

Feedback from the workshop sessions will be used to prepare the Lanarkshire Capability Framework for national consultation. A number of existing educational/training and learning opportunities currently meet some of the needs identified. Through discussion, locally and nationally, it is clear there is a keen desire to highlight, and where possible to utilise, the relevant educational resources which currently exist. There is emerging consensus that new educational resources should only be developed to address areas where gaps are evident.

Work has therefore commenced within the Lanarkshire project to map these educational resources, their current level of accreditation and identify how they would support the capability framework. HEI's are being contacted to contribute to this exercise. A directory of existing education and training relevant to the intermediate care capability framework will be compiled. It is anticipated that this will signpost staff and reviewers to select the appropriate educational solution to assist them within a particular domain and at a level appropriate to their role and remit. Furthermore, and of particular importance within intermediate care services, it will allow staff to continue to review and to further develop their roles as service models evolve.