

Intermediate Care: Lessons from a Demonstrator Project in Fife

Fraser Mitchell

Team Manager, Social Work Service, Fife Council, UK

Claire Dobson

Lead Physiotherapist/Rehabilitation Co-ordinator

Anne McAlpine

Head Occupational Therapist/Rehabilitation Co-ordinator

Siobhan Dumbreck

Clinical Pharmacist

Ian Wright

Clinical Pharmacy Manager

Fiona Mackenzie

Locality Clinical Manager

NHS Fife, UK

Contact details: fiona.mackenzie3@nhs.net

ABSTRACT

This article reports on the experiences and outcomes of a demonstrator project in Fife aimed at improving intermediate care services. The project focused on three strands: workforce development, extended access and pharmacy. The outcomes provide valuable information to guide future developments in intermediate care services.

KEY WORDS

intermediate care; organisational development; workforce development; pharmacy; extended access

Introduction

The development of intermediate care services is widely regarded as the key to tackling delayed discharge and reducing emergency admissions (Glasby *et al*, 2008). There has been a key divergence between the policies outlined

for older people in England and Scotland in intermediate care, Scotland placing more emphasis on **integrated care** rather than making any specific reference to **intermediate care** (Petch, 2003). The term 'intermediate care' has not been commonly used or defined in Scotland

in the past, but local partnerships are increasingly identifying the potential benefits of developing intermediate care services (Joint Improvement Team, 2007).

In December 2008 the Scottish Government Joint Improvement Team (JIT) invited applications from partnerships in Scotland to become demonstrator sites of intermediate care services. A project board was formed to include managers from across the health and social care partnership. The funding application was guided by an extensive needs assessment of intermediate care services recently carried out in Fife. This report acknowledged the development of intermediate care initiatives in Fife, but recognised that a number of different teams providing similar services could benefit from a more co-ordinated approach at local level (Gilmour *et al*, 2009). A study of hospital discharge of frail older people with complex needs in Fife recognised that intermediate care services are often insufficiently linked to mainstream services (Mitchell *et al*, 2010).

The project's aims were to further develop the Fife-wide intermediate care system, to increase capacity, flexibility and responsiveness. This was tackled by three separate, but linked, project strands:

- workforce and organisational development, to enhance the knowledge and skills of staff and to work towards an integrated intermediate care system
- extended access, to improve access to intermediate care by extending the hours when assessment and care management are available
- pharmacy, improving pharmacy input into the intermediate care system.

Following the selection process, five partnerships were awarded funding of up to £100k by the Scottish Government for a one-year project in their locality. Fife's application for demonstrator status

was successful, and in April 2009 became one of five demonstrator sites in Scotland.

Workforce and organisational development

Nationally, there is a lack of clarity on who makes up the intermediate care workforce and the roles that staff are required to perform. This makes it difficult to know how many workers in each field should be trained and what their training needs are (Nancarrow, 2004). In Fife, we focused our workforce development on those staff whose main remit was intermediate care, defined locally as prevention of hospital admission and early supported discharge. The workforce development strategy was informed by a learning needs analysis, conducted with these staff from a range of professional and support worker backgrounds. The investment in workforce development was spread across a range of interventions and grades of staff, in an attempt to achieve sustainable improvement in the skill base of the workforce and to begin the process of organisational cultural transformation.

Learning needs analysis

A postal survey was sent in June 2009 to all staff in the intermediate care teams across Fife to identify strengths, and knowledge and skill gaps. The survey identified the need for additional training on working with clients with mental health problems including dementia, and training in 'soft skills' (negotiation, conflict management, risk management and coping with change). Some staff (mainly from a social work service background) felt isolated in their work, and staff across disciplines felt that intermediate care was not recognised as a mainstream service.

The results of the learning needs analysis were used to direct staff training and development resources to enhance the knowledge and skills of staff and to strengthen the organisational capability of the intermediate care service.

Workforce development

Carer awareness

Family and other informal/unpaid carers play a vital role in helping to support recipients of intermediate care services, and the demands of being a carer can at times be difficult for family members. Greater awareness of the needs of informal carers was seen as an essential skill for intermediate care staff from all backgrounds.

The training consisted of a series of half-day workshops provided by the Fife Carers' Centre aimed at improving staff knowledge and awareness of carers' issues. All participants rated the training positively, and all stated that their knowledge and understanding of carers' issues had increased.

Capability framework

Capable, Integrated and Fit for the Future: A Multi-agency Capability Framework for Intermediate Care (NHS Education for Scotland) was introduced to intermediate care teams across Fife. In conjunction with the Capability Framework an electronic database of all training and learning opportunities in the partnership relating to intermediate care has been developed. This has helped staff to identify and access relevant training to meet specific needs.

The effectiveness of the initiative was evaluated by the University of the West of Scotland. In the initial stages of the project both managers and staff were extremely positive about the Capability Framework. However, the take-up of use of the framework was disappointing, pressures of work being given as the reason why it was not being implemented more fully. Staff who had the opportunity to use it reported finding it of benefit in providing a framework to help them recognise their strengths and identify learning needs.

Training for staff not professionally qualified

Increasingly, tasks are being delegated from highly skilled, high-cost workers to less qualified, lower-

cost workers, freeing more highly trained staff to undertake more specialised work (Nancarrow, 2004). Appropriate use of support workers can also help to create a seamless service that bridges the gap between health and social care and to improve services to users by combining social care with rehabilitation skills (Ottley *et al*, 2005). To achieve successful task delegation, support workers (especially those from caring backgrounds) require appropriate training in rehabilitation and re-ablement, and the confidence to know when they have reached the limits of their capability (Nancarrow, 2007). A significant resource of the intermediate care services in Fife is invested in qualified care/support staff who are not professionally qualified.

Thirty care assistants working in intermediate care settings have been supported to undertake Scottish Vocational Qualification (SVQ) Level 3 in Health & Social Care. Delivery of the training demonstrates the strength of partnership working in Fife; all the participants are council employees, but the delivery is undertaken by NHS staff.

Leadership and integrated service improvement

Four staff from NHS Fife and Fife Social Work Service were sponsored to undertake an MSc in Integrated Service Improvement: Health and Social Care at the University of Edinburgh. The cohort has successfully completed the first year and all candidates are enthusiastic about the skills they have learned in service evaluation and integrated working. As one student said:

'The MSc has helped me to develop the skills to take a leadership role in service development work in the CHP around intermediate care.'

Dementia studies

Three staff in the partnership from health, social care and housing backgrounds have been funded to undertake the Certificate in Dementia Studies at the University of Stirling. The learning

needs analysis highlighted the challenges staff face in meeting the needs of people with dementia in intermediate care services, and a perceived lack of knowledge, skills and experience in the staff group.

Organisational development

Intermediate care services frequently span the boundaries between community and hospital services. Fife has a number of discrete teams providing intermediate care, which presents challenges in co-ordinating access to these services and links with the wider service community. Organisational development through structural reform alone is unlikely to lead to integrated service improvement, and any attempt to change must recognise professional cultures and sub-cultures in which individual staff members and groups of staff understand the nature and value of integration in different ways (Williams & Sullivan, 2009). Organisational culture has been seen as a crucial variable in the management of organisational performance (Davies *et al*, 2000).

The training needs analysis conducted in 2009 identified a number of organisational cultural issues which had to be addressed to progress the development of intermediate care services. The key issues identified included inter-agency/inter-disciplinary role clarity and understanding, inter-agency/inter-team communication, and the need for a shared intermediate care identity. There was ambiguity about the meaning of 'intermediate care', and there is a perception that intermediate care services are poorly understood by other service providers and users. Overall, there was a perception of fragmentation of service provision in the intermediate care sector as well as inconsistent linkages with the wider service community. This mirrors the findings of a national evaluation of intermediate care services in England (Glasby *et al*, 2008). The interface between intermediate care and mainstream

services, combined with poor co-ordination between intermediate care services, emerged as the main weakness in the results from five case study sites in England (Regen *et al*, 2008). Recent Department of Health guidance in England recommends integration with mainstream health and social care (DH, 2009).

Following a diagnostic exercise, the NHS Fife Organisational Development Team facilitated a two-day development session based on dialogue principles to support a cross-section of intermediate care staff to address these issues. Dialogue is an approach to organisational learning across cultural boundaries that can encourage organisational transformation (Schein, 2003). This event explored underpinning principles, the purpose of intermediate care, the resources available in each locality and consideration of the future of intermediate care in Fife. Not all participants were comfortable with the style of interaction promoted by the 'dialogue' event, which was intended to explore in a large group setting individual perceptions of the intermediate care service, rather than to make decisions or solve problems. This event will be followed by smaller, local events which will build on shared learning to facilitate service integration.

Extended access

The demonstrator project increased the availability of access to the existing intermediate care services in one locality in Fife. The extended access arrangements were focused on the integrated response team (IRT). IRT provides a rehabilitation service to support people after discharge from acute hospital, or prevent inappropriate admissions to hospital. This service is provided in the patient's home over a 14-day period. A multi-disciplinary team, from health and social work, provides assessment from 09.00–17.00 Monday–Friday, and generic rehabilitation assistants provide daily support between the hours of 8am and 10pm every day.

The availability of professional staff to provide assessment and care management was extended to Wednesday, Thursday and Friday evenings until 19.00, and on Saturdays from 09.00–14.00. These times were based on information from the local hospital Accident & Emergency Department and data on week-end referral patterns to community health services provided by the primary care emergency service.

Thirty-four patients were assessed as part of the extended access hours project. As a result, 11 hospital patients were supported to go home in the out-of-hours period, and three clients were supported to remain at home following a medical emergency, which prevented hospital admission. The low ratio of prevention of admission interventions to early supported discharge work is reflected in findings from other studies (Glasby *et al*, 2008; Kaambwa *et al*, 2008).

Patient experience

There is considerable scope for increased service user involvement in service development for intermediate care (Andrews *et al*, 2004). The intermediate care demonstrator project involved patients in face-to-face interviews about their experience of the service. From the 34 patients who had received the extended access service, a random sample of 12 patients were invited to participate in the interviews. Six patients agreed to participate and were interviewed at home.

The interviews were held in the service user's home and were based on the 'Talking points: personal outcomes approach developed by the Joint Improvement Team and focusing on the outcomes important to the patients (Miller & Cook, 2009). All the patients questioned felt that the service listened to them, and that care and support were provided at a time and a frequency that suited them. The responses indicated that the team delivered a flexible, person-centred service that treated patients with respect. All patients said that they felt safe when receiving the intermediate care service, and continue to feel safe.

This comment is representative of the responses received regarding safety.

'I preferred to be at home and felt very safe at home. I felt safe knowing someone was coming in to help me.'

The results provide strong evidence that the service enabled patients to return to their previous level of ability in activities of daily living. Patients commented that they felt more confident in their ability to cope at home. All the patients had returned to the social activities that they had managed before their recent hospital admission, and all those interviewed were managing to get out of their home. Re-engagement of older service users in social networks has associated benefits for restoring physical health and psychological well-being (McLeod *et al*, 2008).

The results of the outcome-focused review have demonstrated that the extended access service was patient-centred and flexible. The patients interviewed felt that the service had fully met their needs, commenting particularly on the combination of rehabilitation and personal care, and that the service helped patients to feel safe.

Staff experience

Eighteen staff from the teams completed a survey to report on staff experience; 83% of staff felt that the integration of new staff into the extended access service had worked well. However, comments suggested that communication between existing and new staff to the IRT could have been better. Perhaps more familiarisation for all staff involved, before the project commenced, would have helped the process of integration.

Staff were asked what they were able to provide during the extended access hours that could not be done within standard working hours. The responses indicated that arranging afternoon discharges from hospital and discharges

on Saturdays, and the ability to complete professional assessments during these extended hours, enabled more flexibility in the intermediate care system.

Six staff from the extended access project participated in face-to-face interviews conducted by NHS Fife Clinical Governance Team. The responses expanded on the difficulties experienced by staff in being unfamiliar with the various operational systems. Positive comments were made about the advantages of staff working across teams and being able to follow patients through their care journey.

The staff involved supported the service redesign and were key to the success of the project in achieving its outcomes. They were willing to change their existing work patterns to trial working out of hours as part of the demonstrator project. This demonstrator has shown that small changes, such as more flexible working in the evening, can have a positive impact in facilitating assessment of patients at an earlier stage in their pathway, thereby enabling earlier supported discharge.

Indicator of relative need (IoRN)

The IoRN is a tool that has been developed by the Information and Statistics Division of the Common Service Agency (part of NHS Scotland) to provide a standardised means of grouping individuals according to their relative need (Scottish Government, 2004). The IoRN is a questionnaire comprising 12 questions (covering activities of daily living, mobility, personal care, food/drink preparation, mental well-being and behaviour, and bowel management) that draw on the information a practitioner will already have gathered from an individual's assessment of need. Answers to the questions provide a score that results in allocation of the patient to an IoRN grouping ranging from A–I, where A represents the most functional ability and I the least functional ability. A total of 298 IoRNs were returned, 279 being completed for

both the beginning and the end of the episode of care with individual patients.

Figures 1 and **2**, overleaf, show the scores at the beginning and end of an episode of care. At the beginning of the intermediate care services intervention, 56% were in the top two (A and B) bands. At the end of the intervention, 73% were in bands A and B (most functional ability). The proportion of patients in categories G, H and I (least functional ability) is relatively small at 11%.

Figure 3, page 33, shows the use of the IoRNs as an outcome measure, and indicates that the great majority of people either maintained their previous level (same group) or showed improvement in their functional ability. Seventy-five clients were reported in band A at both the beginning and the end of the episode of care, which means that no improvement can be recorded for these patients using the IoRN tool. Nineteen of the IoRNs returned were completed only at the beginning of the episode of care, because the patient had been admitted to hospital or institutional care or had died.

The large number of IoRNs completed during the demonstrator indicates that staff were able to complete this tool effectively and efficiently. Staff supported use of the tool, which has given a clear picture of the types of client in intermediate care and its effectiveness as an outcome measure. The overall conclusion from the results shown by the IoRN is that, during an episode of intermediate care, the great majority of people were either maintained at their previous level of function or improved by at least one grouping.

Pharmacy

Medication issues can arise with intermediate care patients. Medicines account for 4–6.5% of emergency hospital admissions from adverse drug reactions, prescribing errors or poor compliance (Petty, 2008). Pharmaceutical care is an integral part of a whole-systems approach to intermediate care, in ensuring that the patient gets the right

Figure 1: IORNS SCORE (%) AT BEGINNING OF CARE EPISODE

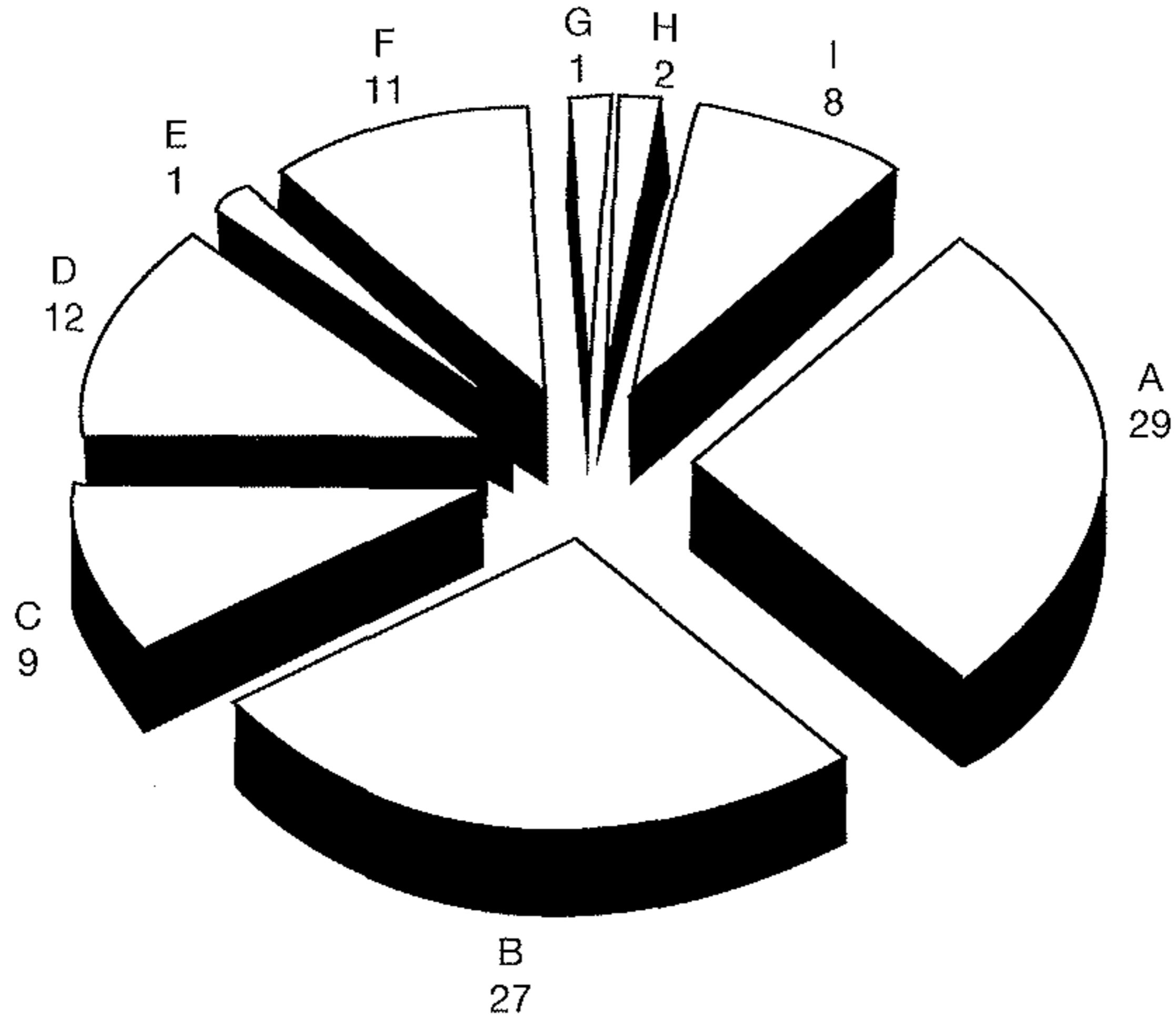


Figure 2: IORNS SCORE (%) AT END OF CARE EPISODE

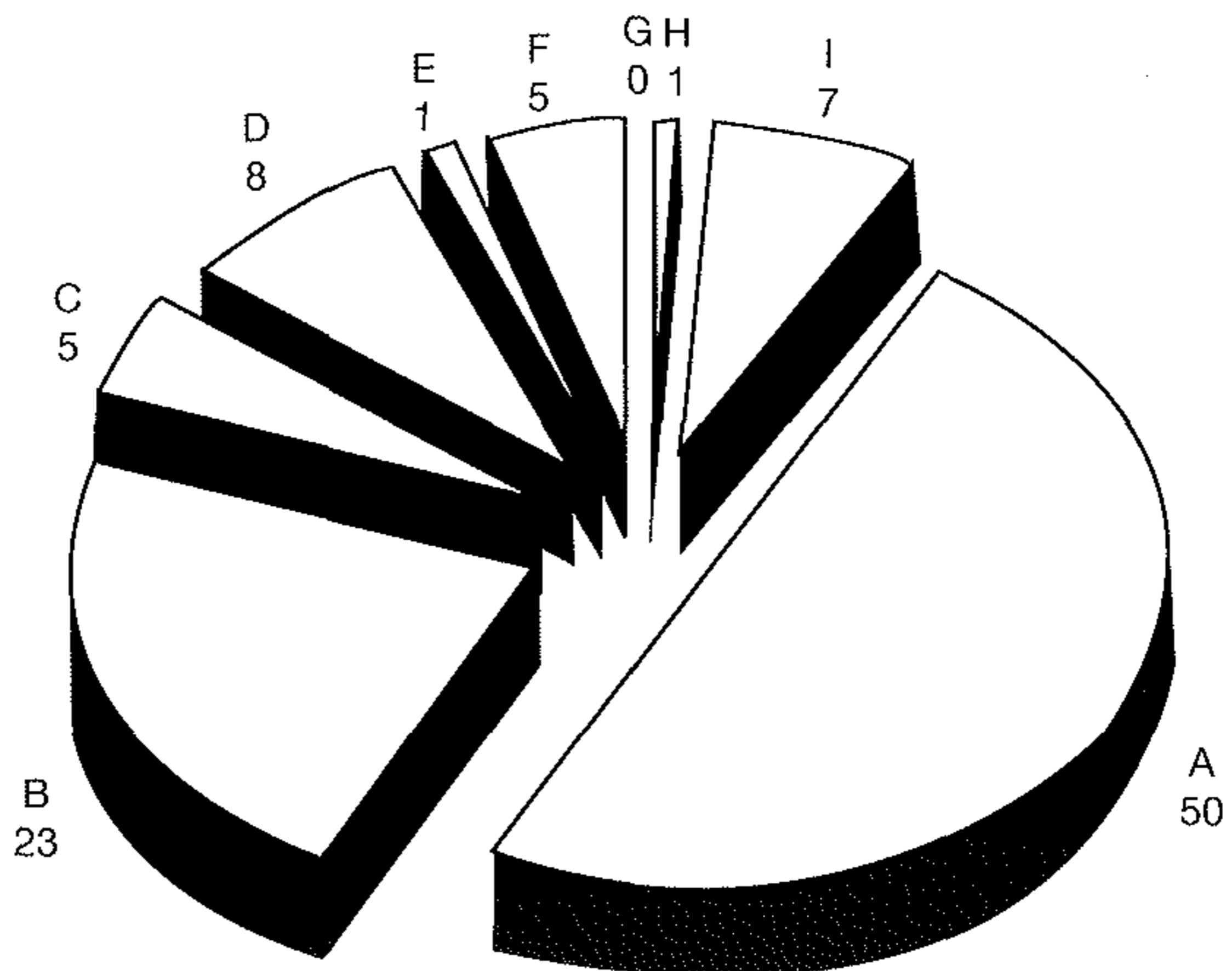
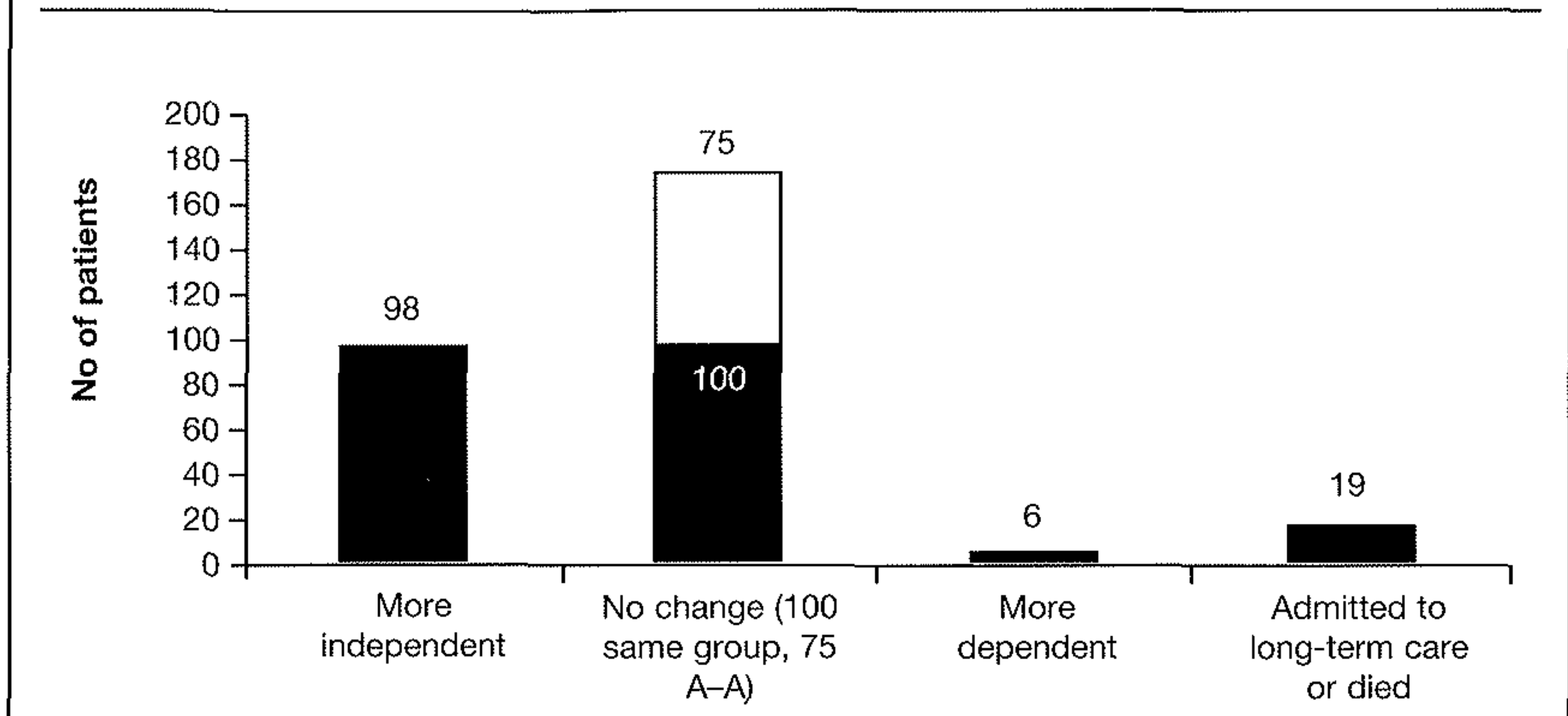


Figure 3: COMPARISON OF IORNS GROUP AS AN OUTCOME MEASURE

medicines, in the right dose, at the right time and for the right reasons. Pharmacy teams can contribute to high-quality care by ensuring optimal medicine management by provision of specialist advice and information.

The pharmacy strand of the demonstrator project was included to advance understanding and knowledge of pharmacy services input into the intermediate care system in Fife, and to provide a solid evidence base for informing system redesign. A part-time (0.6 wte) pharmacist was employed for six months to undertake this work.

Pharmacy is not an isolated activity and, with an ageing population, it will have increasing importance for every aspect of the pharmacy service. Community pharmacists are the key points of access to the pharmacy service. The implementation of the Chronic Medication Service in Scotland creates a responsibility for community pharmacists to develop care plans for patients with long-term conditions who are assessed as being at risk. Community pharmacists should be integral to the care pathway into the intermediate care system, taking referrals from any member of the health

or social care team who identifies that a patient is experiencing problems with medication. The single shared assessment (SSA) tool used in Fife was recently revised to incorporate four trigger questions to support appropriate referrals to community pharmacy (Oboh, 2006).

- Do you need help in getting a regular supply of your medicines? (Access)
- Can you swallow and use all your medicines and get all your medicines out of their containers? (Day-to-day management)
- Do you always take all your medicines in the way that your doctor wants you to? (Compliance and concordance)
- Do you think that some of your medicines could work better? (Clinical)

The demonstrator project has shown that a lead pharmacist for intermediate care has been beneficial in providing direct advice to patients on medication, and has offered specialist advice to intermediate care staff. Having a lead pharmacist for intermediate care has enhanced strategic links with other services. The project pharmacist was a point of contact for key

stakeholders, to provide an overview of the pharmacy service for intermediate care patients.

Identifying patients in contact with intermediate care services is a convenient way to identify individuals who would benefit from pharmaceutical intervention (Beswick *et al*, 2008). Having a clinical pharmacist as a member of the multi-disciplinary team, with direct responsibility for advising on medication, can reduce the rates of mortality and hospital admission (Triller & Hamilton, 2007).

A weakness of the present intermediate care system is the interface with the hospital service. Community pharmacists can have up to three months to conduct an initial pharmaceutical risk assessment for one of their Chronic Medication Service patients. If hospital wards do not have pharmacist cover, there may be insufficient responsiveness for the urgent pharmaceutical care of patients who have recently been discharged from hospital or who have complex care issues. A potential role for a pharmacist linked to the intermediate care service would be to work with hospital pharmacists to establish a baseline of emergency hospital admissions to which medication has been a contributory factor.

Pharmacy case study

A Care of the Elderly consultant referred to the project pharmacist a patient who was experiencing multiple falls each week, resulting in frequent emergency hospital admissions. Falls had continued despite input from physiotherapy and occupational therapy. Pharmacist intervention focused on gradual reduction of benzodiazepine medication to the clinically appropriate level, in liaison with the general practitioner, and providing advice on medication compliance and sleep hygiene. The outcome was compliance with the reduced medication regime and a significant reduction in the number of falls and hospital admissions.

Conclusion

The intermediate care demonstrator project consisted of three strands: workforce and organisational development, extended access and pharmacy. The project has advanced the understanding and knowledge of the intermediate care system in Fife, and provides a solid evidence base to inform future integrated service improvement.

The workforce and organisational development strand has invested for the future in both a targeted, intensive way with key leaders in the intermediate care system and in a broader approach to staff skills development and organisational development. There are early positive indications that the investment has improved the leadership and service evaluation skills of team managers, is increasing the skill base of a wide range of professional staff and care assistants, and has started the process of organisational change, moving towards a more integrated intermediate care network supported by a single point of access.

The extended access pilot has shown the value of increasing the accessibility of professional staff to carry out assessments and provide care management during evenings and week-ends. It has been especially successful in allowing more flexible discharges from the acute hospital to home. This strand has demonstrated that staff, when fully involved in planning the service, are willing to work more flexible hours. Appraisal of the service by a blend of a personal outcomes approach and a functional assessment with service users has been successful, and has been augmented by a survey of staff views. This inclusive approach to assessment avoids the dangers in applying global constructs to individual experiences, and accepts user-defined goals as legitimate success outcomes (Andrews *et al*, 2004).

The pharmacy strand of the demonstrator project has piloted a unique approach to

supporting intermediate care service users and staff. Given the complex medicines regimes experienced by many intermediate care patients, there were clear benefits in having a pharmacist as a core member of the intermediate care service.

The learning provided by the demonstrator project has been widely disseminated and has been taken up by the Fife Health & Social Care Partnership to inform integrated service development and to ensure sustainability. Nationally, the lessons from the five Scottish demonstrator sites are contributing to the development of guidance by the Scottish Government.

Key learning points

- A project management approach, involving key stakeholders on the project board, ensured a focus on outcomes and provided governance of the project.
- Involve staff and service users and carers in measuring outcomes.
- The involvement of representatives from finance sections and human resources from across the Health & Social Care partnership is required to address joint commissioning and staffing issues.
- A communications plan for the intermediate care service and wider workforce aids engagement and understanding.
- Celebrate success by hosting an event for staff and a publication that captures the progress and learning achieved during the life of the project.
- Sustainability – it is essential to have a plan that will mainstream service improvement.
- Invest in the long term, especially in staff skills and organisational development.
- Staff, when fully engaged in service redesign, are willing to alter existing working patterns and participate fully in the evaluation.
- Use of the Indicator of Relative Need (IoRN) tool has provided a profile of the functional

ability of people using intermediate care services, and has a role in measuring outcomes.

Acknowledgements

The Fife Intermediate Care Demonstrator Project Board would like to acknowledge the contribution of the Scottish Government Joint Improvement Team with regard to funding and advice on evaluation.

References

- Andrews J, Manthorpe J & Watson R (2004) Involving older people in intermediate care. *Journal of Advanced Nursing* **46** (3) 303–10.
- Beswick A, Rees K & Dieppe P (2008) Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *The Lancet* **371** 725–35.
- Davies H, Nutley S & Mannion R (2000) Organisational culture and quality of health care. *Quality in Health Care* **9** 111–9.
- DH (2009) *Intermediate Care – Halfway Home: Updated Guidance for the NHS and Local Authorities*. London: Department of Health.
- Feachem R, Sekhri N & White K (2002) Getting more for their dollars: comparison of the NHS with California's Kaiser Permanente. *British Medical Journal* **324** 135–43.
- Gilmour M, Valentine J & McLaren G (2009) *Provision of Intermediate Care for Older People in Fife: A Needs Assessment*. NHS Fife/Fife Council.
- Glasby J, Martin G & Regen E (2008) Older people and the relationship between hospital services and intermediate care: results from a national evaluation. *Journal of Interprofessional Care* **22** (6) 639–49.
- Joint Improvement Team (2007) *Intermediate Care in Scotland: A Partnership Approach*. www.jitscotland.org.uk/knowledge-bank/publications/intermediate-care.
- Kaambwa B, Bryan S, Barton P *et al* (2008) Costs and health outcomes of intermediate care: results from five UK case study sites. *Health and Social Care in the Community* **16** (6) 573–81.
- McLeod E, Bywaters P, Tanner D & Hirsch M (2008) For the sake of their health: older service users' requirements for social care to facilitate access to social networks following hospital discharge. *British Journal of Social Work* **38** 73–90.

Intermediate Care: Lessons from a Demonstrator Project in Fife

Miller E & Cook A (2009) *Talking Points: A Personal Outcomes Approach Support Pack for Staff*. www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/staff-development-materials.

Mitchell F, Gilmour M & McLaren G (2010) Hospital discharge: a descriptive study of the patient journey for frail older people with complex needs. *Journal of Integrated Care* **18** (3) 30–6.

Nancarrow S (2004) Dynamic role boundaries in intermediate care services. *Journal of Interprofessional Care* **18** (2) 141–51.

Nancarrow S (2007) The impact of intermediate care services on job satisfaction, skills and career development opportunities. *Journal of Clinical Nursing* **16** 1222–9.

NHS Fife/Fife Council (2010) *Fife Intermediate care Demonstrator: Final Report*.

NHS Education for Scotland. *Capable, Integrated & Fit for the Future: A Multi-agency Capability Framework for Intermediate Care*.

Oboh I (2006) Pharmacists can help improve older people's medicines management. *Pharmaceutical Journal* **276** 206–7.

Ottley E, Tongue A & McGill M (2005) Redefining the role of support workers in intermediate care: key findings from a national project. *Journal of Integrated Care* **13** (1) 28–34.

Petch A (2003) Intermediate care or integrated care: the Scottish perspective on support provision for older people. *Journal of Integrated Care* **11** (6) 7–14.

Petty D (2008) Can medicines management services reduce hospital admissions? *Pharmaceutical Journal* **280** 123–6.

Regen E, Martin G, Glasby J *et al* (2008) Challenges, benefits and weaknesses of intermediate care: results from five UK case study sites. *Health and Social Care in the Community* **16** (6) 629–37.

Ryan C, O'Mahony D & Byrne S (2009) Application of STOPP and START criteria: interrater reliability among pharmacists. *Annals of Pharmacotherapy* **43** 1239–44.

Schein E (2003) On dialogue, culture, and organizational learning. *Reflections* **4** (4) 27–38.

Scottish Government (2004) *Single Shared Assessment – Indicator of Relative Need*. www.scotland.gov.uk/Publications/2004/08/19652/40276.

Triller D & Hamilton R (2007) Effects of pharmaceutical care services on outcomes for home care patients with heart failure. *American Journal of Health System Pharmacy* **64** (21) 2244–9.

Williams P & Sullivan H (2009) Faces of integration. *International Journal of Integrated Care* **9** 1–13.