Implementing a Step Down Intermediate Care service

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Abstract

Purpose – The purpose of this paper is to explore implementation and development of step-down intermediate care (IC) in Glasgow City from the perspective of staff.

Design/methodology/approach – The study used qualitative methods. Nine key members of staff were interviewed and three focus groups were run for social work, rehabilitation and care home staff. Framework analysis was used to identify common themes.

Findings – The proposed benefits of IC were supported anecdotally by staff. Perceived enablers included: having a range of engaged stakeholders, strong leadership and a risk management system in place, good relationships, trust and communication between agencies, a discharge target, training of staff, changing perception of risk and risk aversion, the right infrastructure and staffing, an accommodation-based strategy for patients discharged from IC, the right context of political priorities, funding and ongoing adaptation of the model in discussion with frontline staff. Potential improvements included a common recording system shared across all agencies, improving transition of patients from hospital to IC, development of a tool for identifying suitable candidates for IC, overcoming placement issues on discharge from IC, ensuring appropriate rehabilitation facilities within IC units, attachment of social work staff to IC units and finding solutions to issues related to variation in health and social care systems between sectors and hospitals.

Originality/value – The findings of this study help the ongoing refinement of IC service. Some of the recommendations have already been implemented and will be of value to similar services being developed elsewhere.

Introduction

Intermediate care (IC) is a term used to describe a provision of services, usually for older people requiring interim care between hospital and home (Stevenson, 2002). Although there are many different models of IC, common to them all is that healthcare occurs somewhere between a social and primary care setting and a hospital (secondary care) setting. IC acts as a bridging service between hospital and home, allowing time for adaptations to be made to the patient's home environment and giving the person an opportunity to recover and regain independence (Scottish Government, 2012). Additionally, a goal of providing IC is a reduction in length of unnecessary stay in hospital beyond the date ready for discharge ("bed blocking"), and freeing up of hospital beds for patients who need them (Steiner, 2002). A study of the effectiveness of nursing-led IC units found that these did result in a better functional status on discharge but the impact on length of stay prior to being moved to the unit was less clear, as were any cost benefits; units were observed to save money in the US but not in the UK (Griffiths *et al.*, 2007).

IC model development in Glasgow City

IC in Glasgow City was first devised under the Reshaping Care for Older People Programme (RCOPP) (COSLA, 2011). During the RCOPP period health and social care partnerships (HSCPs) were formed across Scotland. Glasgow was the only area that had previously attempted this integration of services previously, making the context for IC unique in Scotland. The first model of IC was Assessment at Home, involving the identification of individuals in the hospital wards who could be discharged home to complete their social care assessment. The main aims were to shift the balance of care away from care home placements to care at home and to reduce days lost to delayed discharge. This model was trialled in one part of Glasgow City in July of 2012 and rolled out in August of 2012. However the model was abandoned in 2013 and a second model of IC- bed-based IC in IC

units in case homes- was implemented in November of 2014. The service was designed to provide a time limited placement (maximum 28 days) in a care home for assessment and rehabilitation, following discharge from hospital. Funding came from the RCOPP, therefore future funding was not known at the outset of the project, although this was subsequently 'mainstreamed', receiving recurrent funding without application. Unlike several IC models being trialled in Scotland during this time, it was decided not to use a screening tool for IC, but to allow IC to act as a screening tool for onward care.

The project involved both health and social services in development and implementation, with social services taking the lead in running the IC service. Acute's involvement is largely prior to discharge, informing patients and their families about the IC service, providing relevant medical notes and information to social services, discharging the patient. Primary care services including GP, podiatry, dentistry input to IC with regular scheduled appointments, while other health service staff such as physiotherapists and occupational therapists assigned to IC units as full time members of staff. IC beds were originally spread across several care homes, although over time the optimal number of beds per unit and ratio of staff to patient has been refined. At the time of this study there was a move towards units of 15 beds (between 8 and 25 had been trialled previously). When established, the IC service developers approached care homes with capacity. At the time of the study, however, a tender process was being developed to allow care homes the opportunity to bid for an IC unit contract. Medical responsibility is that of the GP contracted to the care home within which the IC unit sits, who receives medical notes from the patient's own GP and subsequently shares their notes when the patient is discharged from IC. GPs are also in direct communication with acute consultants following discharge from hospital. At the time of the study Glasgow City IC had approximately 15 new admissions (including readmissions) each week and the average age of patients was

approximately 85 years and 75% were female. The project has evolved over time and continues to be refined and improved.

Glasgow City is split into three sectors- North East, North West and South- each having some degree of autonomy within the larger HSCP. Previous research has found models of care to be interpreted differently by sector, due to factors including sociodemographic differences within the resident population, managerial preferences, and inter-agency relationships (Levin *et al.*, 2018). The number of patients delayed in hospital differed by sector even after implementation of the IC service (Glasgow City Health and Social Care Partnership, 2015). Between-sector comparison of health services is commonly used to inform on-going refinement of the service.

IC and Delays in hospital discharges

Discharge delays can occur for a number of reasons but most commonly these are due to a lack of appropriate care or support within the community (NHS Information Services Division Scotland, 2016). A community care assessment is undertaken by health and social care professionals, to assess the needs of the patient in a community setting on discharge from hospital. Elderly people may need adaptations to, or a complete change in, their accommodation, which can take time to arrange. In April 2015 a national target was introduced, that delays for patients deemed medially fit for discharge should not exceed 14 days (Scottish Government, 2016). Glasgow City, however, set its own discharge target of 72 hours from point of being ready for discharge, first in the North East sector in December 2014, and across the rest of the city in February 2015.

The IC service in Glasgow City was associated with reductions in days lost to delayed discharge (Levin *et al.*, in submission). However, following an immediate reduction in the rate of days delayed, subsequent increases were observed, albeit at a slower reduction than if IC had not been in place. The aim of this study was to explore implementation of the IC service, service development and variation, from the perspective of staff, in order to understand components of the service that worked well and those that could be improved.

Methods

Setting, participants and data collection

The study used semi structured interviews and focus groups. Data collection was conducted between May and October 2016. Nine key members of staff were selected for interview from the agencies involved in IC: Social Work's head of Transformational Change, liaison nurse, service manager for older people in primary care, rehabilitation manager, speech and language therapist, service manager for older people and physical disability, consultant physician in medicine for the elderly, GP working in two IC units and discharge team lead for acute hospitals. Three focus groups were run; the first included 6 IC social work staff - social workers and social care workers- from the three sectors, the second included 4 rehabilitation staff - physiotherapists and occupational therapists- from two sectors, and the third included 6 care home staff from three IC units operating in two sectors.

Digital recording and verbatim transcription methods were adopted. In addition, observational notes were made of nonverbal contributions and researcher observations. Descriptive and reflective notes were formalized immediately following focus groups and interviews. Interview and focus group schedules, the Coding Framework and Coding Book are available on request from the author.

Data analysis

The data were analysed using thematic framework analysis (Gale *et al.*, 2013), to develop themes. Deductive coding was used, based on a coding rubric, and inductive coding, to capture new themes. Several iterations of comparison were adopted to identify common themes. Over-arching themes from the interviews and focus group were identified, and a meta synthesis brought these together.

Results

Interviews and focus groups participants discussed their role within the IC service and wider health and social care pathway and seemed to enjoy the opportunity to compare experiences and vent frustrations. The semi structured approach allowed conversation to flow and explore unexpected avenues. Participants were forthcoming with their thoughts and opinions, citing several examples of situations to illustrate their points. Analysis of the datasets resulted in 6 main themes relating to implementation of IC which are described below.

Theme 1: An integrated workforce working towards a common goal

A common theme that arose in discussion was the need for all stakeholders involved in IC to establish strong working relationships and work together towards a collective goal. A history of strained relations between social work and acute care was described and it was felt there was a need for this to be resolved at a managerial level before IC could work optimally. Methods of joint working included the introduction of the liaison nurse role between acute and social work, early goal planning meetings and weekly multidisciplinary meetings thereafter, directly engaging with families, having a consistent workforce by assigning social work and rehabilitation staff to IC units, and having

a smaller number of units. Additionally, understanding the benefits and complexities of having so many agencies involved, overcoming a blame culture, having the technological systems in place to allow sharing of information between social work, acute and GPs and rehabilitation staff, and having a joint accountability framework were considered to be critical to joint working and ensuring a coordinated transition of patients from hospital to IC and onwards.

"If you can do it and you can move to the next step of their journey, do it, *then* you work out why somebody else hadn't done it later on. And people were shying away from that at first because they'd worked in very clear silos, 'oh no they pay for that and I'm not doing that. I've sent it back for them to order'." [*Participant TL1NS*]

Bringing frontline staff together from all sectors and sharing best practice and novel methods was found to be beneficial. Training care home staff in a reablement approach encouraged a move away from long term care methods, and on-going education of acute staff, GPs and social workers out with IC in the role of the service were important due to staff turnover and the newness of the service. Keeping risk registers within each unit, using an escalation process for dealing with difficult situations and having governance in place describing joint aims and accountability were raised as beneficial in overcoming and preventing specific challenges. The timing of goal planning meetings on admission to IC and subsequent multidisciplinary meetings thereafter varied between sectors. Finding a time suitable for all parties caused delay in one sector, while in another, striving to meet the 48 hour target meant that family sometimes could not attend or rehabilitation staff had not had time to assess the patient. Recruitment and retention of staff was a concern, with particular risk regarding GP coverage. GP contract termination required only 3 months' notice, leaving little time for care home providers to find a replacement practice.

Theme 2: Political priorities and political focus on the service

Several participants recognised that under the RCOPP this project received greatest sum of money, and equated this to a focus on achieving positive results, believing that the combination of scrutiny and resource was pivotal to the success of the service. In particular, the use of targets and subsequent pressure and scrutiny on performance was thought to be critical to the success of the service. In particular, the target introduced in Glasgow City at the start of 2015, that there should be no delays in hospital discharge longer than 72 hours, was mentioned by all participants interviewed. This was believed to be one of the biggest drivers, forcing a change in discharge methods and developing the transition of patients from acute to IC. Some participants, specifically service managers and the speech and language therapist nurse, described the need for a particular political climate and focus on integration at a national level, and subsequent funds made available, for the service to work.

Theme 3: Wider context and replicability

Participants discussed the relevance of the wider context, IC models in other parts of the country and the fact these could not be simply replicated in Glasgow City as these were dependent on health and social care services, housing and the voluntary sector in any given location. Participants described sector level differences in the population affecting levels of need and variation in health systems and the methods used within hospitals, variation in care home availability; in particular, there was recognition that in Glasgow City there was greater care home availability than in other parts of Scotland, making it possible to acquire units for IC. The importance of having appropriate housing available was raised, to make adaptations to homes and provide technology such as key safes for individuals, in order to create a feasible environment for people to go home to. Difficulties

encountered included working with different local authorities and social and care partnerships and their respective available resources. Changes in care pathways such as the discontinuation of NHS continuing care beds were thought to result in a change in the population admitted to IC.

The impact of IC on social services, primary care and secondary care were discussed. IC was thought to encourage acute staff to think differently about outcomes for patients and their rehabilitation potential. IC was seen to increase the workload of social services and many primary care staff including district nursing, community psychiatric nurse services, GPs, podiatry, dental services and opticians. Participants described more complex frail patients being treated in primary care as a consequence of IC. There was some discussion about the importance of transportation services for patients between hospital and IC, housing options and blockages caused by oversubscribing to supported living, sheltered housing and residential placements.

Sector and unit level differences in the model were described in focus groups. Attachment of social work, care home and rehabilitation staff to IC units was considered to be a preferable model among all staff. Participants described variation in care home ratings, rapidly changing ratings, and the lack of control over quality of care due to using external providers. Tracker sheets and logs were described to monitor safety. Three of the four care home staff that participated described working within the unit, while the fourth described working "both upstairs and downstairs" [*participant CHP1S3*], in IC and in the nursing home.

Theme 4: On-going development of the service

Successful development of the service was thought to be due to involving frontline staff at early and on-going stages, allowing them to feed back their experiences and opinions. Agencies had to be responsive, learn quickly and adapt to changes. Developments included refining the size of the units, staffing, number of beds, and the number of GP sessions, to achieve optimal bed occupancy and benefit from economies of scale. Explicit staffing ratios (trained to untrained nursing staff), beds and GP requirement were detailed in a second round of invitation to tender in April of 2016. This study was carried out during the tender process so that the results were not known but participants described the changes they anticipated and their optimism that these would address some issues within IC.

Participants described bed blocking within the IC units and spot purchasing of care home beds for patients during busy periods to relieve pressure. Some felt that service development occurred in response to a crisis, rather than following observation and reflection at a managerial level. Almost all participants raised the changing cohort of patients which some believed was due to the end of spot purchasing, while others thought was the impact of the discontinuation of acute continuing care beds. Social work's involvement from the point of entry to hospital, rather than at point of discharge, was raised as a possible future development of the model. In NE, some patients were allowed a trial period of returning home, which all participants thought would be a good development that might prevent patients from becoming institutionalised.

Theme 5: Perception of risk and risk aversion

Participants felt that controlled environments such as the hospital ward used a risk averse approach, often resulting in patients being unnecessarily bed ridden and having everything done for them. Additionally, it was felt that geriatricians had been initially nervous to discharge patients to care

homes with no geriatrician input and what they perceived to be a low nursing resource. Training events were held with rehabilitation and social work staff around using a risk enabling approach. Similarly, care home staff were trained in a reablement focus, encouraging independence in the patient, described as being quite different to the approach taken for long term care residents. It was felt that historically the impact of risk aversion coupled with the pressures of bed blocking resulted in patients being sent to a care home unnecessarily and that IC prevented risk averse decision-making of this type.

Risk aversion was also perceived among families, carers and patients, with people becoming more dependent the longer the hospital stay. It was felt that IC gave patients, rather than their families, the opportunity to be more involved in the decisions regarding their future. IC staff also helped families with paperwork for sheltered housing, find local befriending groups and day centres and overcome fears of coping or living in isolation. Conversely, participants also described needing to manage the expectations of families and carers, for those people hoping to have their family member return home when this was not a realistic option. IC allowed family members the opportunity to come to terms with the need for a care home placement in such cases, and alleviate fears and misconceptions by experiencing what a care home placement might be like for them and their loved one.

Theme 6: The client group, patient's rights and expectations

Participants described IC models where a screening tool was used to gain entry to IC, unlike the model used in Glasgow City which was open to most people. However participants noted that some patients that previously would have been referred for palliative care had they been allowed to remain in hospital a little longer, ended up inappropriately in IC. Multiple moves for those with

cognitive impairments were also deemed unsatisfactory. IC was thought to raise expectations of going home, when it was clear that this was often not a feasible option. Participants described patients arriving in IC for whom they felt there was absolutely no dubiety that they were going to a nursing home and for whom IC was therefore not suitable. Examples were given, however, of patients that were thought to have no rehabilitation potential in hospital and who did go home following a stay in IC. In general, there was an acknowledgement of it being difficult to screen for IC and that no adequate screening tool had yet been identified. Discussions were around both screening to enter IC but also screening within IC, with the belief that a tool to do the latter could be used to direct resources and define targets by patient group. It was felt that having social workers in the hospital ward would help assessment of suitability for IC.

"I think the problem was that it was felt that we are not very good in hospital at identifying between these two. The people that we say no rehab potential might turn out to have and vice versa, some people we think might have rehab potential, might not." [*Participant TL7NS*]

Patients had to agree to be moved to IC. Rehabilitation staff spoke of the patient and family's misperceptions of IC, often falling either towards this being a long term care placement or having been 'sold' an opportunity for rehabilitation where a lack of facilities in units prevented this.. A further problem was placement of individuals in care homes following a stay in IC. People often would not leave IC until they got the care home placement they wanted, staying beyond the allotted 4 weeks. Participants felt patients should be charged if they chose to reject an offer of a long term placement and remain in IC awaiting a preferred placement.

Discussion

Delays in discharge are costly to the NHS and particularly in the case of the elderly, lower patients' confidence and leave them susceptible to infection, malnutrition and deterioration of cognitive function (Jasinarachchi *et al.*, 2009). Following implementation of IC in Glasgow City, the number of bed days lost to delayed discharge reduced (Levin *et al.*, in submission). However, subsequent increases in delays and intermittent periods where blockages have resulted in spot purchasing of care home placements, suggest refinement in component parts of the service may be required. Additionally, sector differences have been observed in delayed discharge trends (Glasgow City Health and Social Care Partnership, 2015). The importance of component parts to the success of IC services has been described previously (Ward *et al.*, 2008). Several models of IC have been trialled nationally and more recently NICE guidance in IC and reablement services has been published (Kendall-Raynor, 2018). The aim of the current study was to find elements of the service in Glasgow City that worked, barriers to its success, and areas that could be improved.

Relevance to the existing literature

Cross-discipline collaboration has previously been described as one of the three main themes for successful transformational change in health systems (Swanson *et al.*, 2012). Studies of intermediate care have identified improved joint working, communication, information sharing, a clear aim, and a strong leadership as key to the success of the service (Cameron *et al*., 2014; Johannessen *et al.*, 2013; Nancarrow *et al.*, 2013; Regen *et al*., 2008). The importance of the local context, location of the facility, the multidisciplinary team, patient-centeredness and patient and family participation in decision making have also been discussed (Asthana and Halliday, 2003; Cameron *et al*., 2014; Salsi and Calogero, 2010). Funding and a lack of resources have been cited as a barrier to the functioning of IC services elsewhere (Regen *et al.*, 2008).

Forging strong relationships and a history of good relations are cited as promoting joint working (Cameron *et al*., 2014). Implementation and management of the IC service in Glasgow City ran into difficulties where relationships existed with a history of challenges, particularly between social work and health (Audit Scotland, 2011). The current study found a collaborative approach was achieved by creating a liaison nurse role working between health and social care in acute and IC settings, having clear governance, joint accountability and common targets. However, further unresolved complexities were highlighted due to the involvement of so many agencies, for example the timetabling of goal planning meetings. Social work and rehabilitation staff assigned to IC units, of approximately 15 beds, , were considered the most effective model for sharing of information, optimising knowledge of patients among staff, and enhancing understanding of the role of GPs and other members of the IC team. A political focus, delayed discharge targets and subsequent scrutiny on performance were considered critical to the success of the service. A period of 'bedding in' of the service required on-going training of staff in the function of IC and in a reablement focus in acute wards and within the care home setting. Early involvement of social work staff in the hospital ward was cited as a possible future development of the model which could help to streamline the process.

Previous research discussed the importance of IC being part of the wider care pathway (Johannessen *et al*., 2013; Regen *et al*., 2008). The current study highlights the impact of health system changes beyond IC, such as the closure of continuing care wards in acute, on client group and availability of services being provided. The study also found that temporary contracts between care homes and GPs leave the service vulnerable; IC services must be quick to adapt to these types of changes within IC and outwith, in the wider care pathway. On-going iterative learning and the ability to react to change were key to the development of the service, in line with transformational change research (Swanson *et al.*, 2012). The service was being refined during the study. The study found that involving frontline staff in the implementation and development of IC was particularly beneficial.

The model used in Glasgow City was unique in Scotland as it used no screening tool for entry, allowing all patients the opportunity to benefit from the service. However, the current study found that screening prior to admission or early on once admitted to the service would be beneficial to avoid admission for those unsuited to IC and create different groups of patients with appropriate targets set for each. This is in line with NICE guidance for IC, recently published in England that recommends patients are assessed and only referred to IC where it is "likely that specific support and rehabilitation would improve their ability to live independently" (Kendall-Raynor, 2018). Achieving a 28-day turnaround proved hard in some cases due to people waiting on their preferred choice of care home placement. One proposed solution was to charge patients or their families for 'extra' time spent in IC in such instances.

Overcoming risk aversion in medical and care home staff was important, for the former to discharge patients to IC, and the latter, to give appropriate care that would enhance rehabilitation of those patients going home and avoid institutionalising them. The current study found that training staff in a risk averse approach at early stages of IC implementation was useful, while subsequent training reinforced this and ensured new members of staff were also trained, particularly among medical and care home teams where staff turnover was greatest. Training has previously been identified as one of ten characteristics underpinning effective interdisciplinary team work (Nancarrow et al, 2013).Risk aversion was also noted among families and patients. In one sector, the introduction of patient trial returns home was beneficial in overcoming this.

Implications for policy and practice

The current study found variation in service and potential for service improvement. The study identifies features of the service that could and should be changed to optimise service delivery. While some have been implemented, for example attachment of staff to units and offering patients trial returns to their homes, others are currently aspirational, e.g. using a tool for screening. Some issues remain unresolved but are highlighted for future consideration, e.g. timetabling meetings and management of patients who remain in IC beyond 28 days. Reporting future developments of the service is recommended. When considering implementation of a similar service elsewhere, the wider context of the care pathway, care home availability, third sector services available in the community, and housing options determine aspects of the IC model. Population characteristics should also be considered. Sector differences in demography in Glasgow City and subsequent impact on service provision have been described previously (Levin *et al.*, 2018). More generally, on-going development of the service after implementation is recommended to create an optimal IC model. Iterative development of this type can take several years, and even once finalised, will need to be adaptable to future changes in the wider context out with IC.

Limitations of the study

This study considered only the views of staff. Future research should be directed at patients and their families. While a GP and geriatrician were included in the current study, it would be useful to conduct focus groups with medical staff as they are key to the care pathway.

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