A discussion paper based on the multidisciplinary and multiagency debate undertaken at the National Intermediate Care Community of Practice

May 2009
Discussion Paper
What Should Intermediate Care Look Like in Wales?

The aim of this paper is to stimulate debate amongst opinion formers in health and social care to ensure that, whilst embracing the diversity necessary to address local need, we are committed to working together to achieve a joint vision for Intermediate Care and genuinely improve the experience of people on their journey through health and social care in Wales.

Intermediate Care is an umbrella term used to describe a range of new and established teams and services that aim to support people closer to home.

Background and Context

Services providing Intermediate Care (IC) sit outside, or more pertinently, alongside traditional mainstream primary and acute health and social care provision. Across Wales and internationally there is a plethora of services with similar and different names set up with similar and different purposes.

Intermediate Care is not about a specific type of service and it's not particularly revolutionary, just an approach to care focussed on maximising the opportunities for everyone to be independent, happy and active within their chosen community.

In general, intermediate services have often been established to shore up gaps in the continuum of care in response to localised demand and to relieve increasing pressure on mainstream services. Although many local initiatives were originally aimed at specific population groups such as the frail elderly, intermediate services generally do not operate policies that omit people through arbitrary limitations such as age.

They do however; tend to target individuals who would benefit from a timely or intensive focus on improving and stabilising their personal condition and social circumstances.

In May 2008 the National Leadership and Innovation Agency for Healthcare (NLIAH) hosted an All Wales Intermediate Care Conference to launch a programme entitled 'Supporting Practice in Intermediate Care Evaluation' (SPICE) which is detailed in Appendix 1. Feedback from delegates at the conference indicated that they would value a Welsh network in which to debate Intermediate Care development and to share experiences, learning and aspirations.

As a result, the NLIAH Change Agent Team (CAT) founded the National Intermediate Care Community of Practice (CoP) and at the first meeting in September 2008 participants began to map the extent of Intermediate Care developments across Wales.

It was evident from this early work that there is a great deal of expertise and resource already committed to developing Intermediate Care. In common with other parts of the UK, individual services have often evolved in response to localised demand rather than, as part of a conscious strategy. This context has created some limitations on the effectiveness of services including the widely published constraints that come with short-term or targeted funding.
From those initial discussions it quickly emerged that there is a common vision and ethos amongst the practitioners and managers involved in delivering Intermediate Care services. The CoP decided that it should take the opportunity to examine the characteristics that will determine the uniquely Welsh approach to Intermediate Care.

This paper is based on the debate undertaken at a further workshop held in Llandrindod Wells on 19th January 2009, which encompassed:

- What service users tell us they want from and value in, IC services
- What the evidence is telling us works or not
- What the experience of practitioners and managers tells us has worked so far
- Where do we go from here?

It is clear that services delivering effective Intermediate Care outside traditional hospital settings, will significantly impact upon the success of a number of Welsh Assembly Government priorities and strategies including:

- Making the Connections
- Designed for Life
- Fulfilled Lives Supportive Communities
- Designed to Improve Health and the Management of Chronic Conditions in Wales
- National Service Framework for Older People in Wales
- Delivering Emergency Care Services
- Designed to Add Value
- National Dementia Action Plan

and the recommendations and responses to Beyond Boundaries and One Wales.

**A Common Story**

The adjacent diagram is an illustration of a reflective story originally articulated by Professor Bim Bhowmick, of Gwent Healthcare NHS Trust, which he has entitled “Going Going Gone Syndrome”.

In essence it describes how a system set up to help people can in fact, be the source of that persons decline and loss of independence, simply because the expertise and compassion of the people at each stage are misdirected by an out of date system.

This story is often used to describe the experiences of frail elderly people or those confronted with a catastrophic episode of ill health. However, the principles of the story resonate with practitioners working across every aspect of health and social care, as it paints a picture of a care system that fails to genuinely put the person at the centre.

Looking for solutions to the “Going Going Gone Syndrome” is the common story behind why many of the existing Intermediate Care Service were originally developed and established.

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**Diagram Details**

- Normally or Just Able
- Acute Ward
- Senior Review
- MDT Decision
- Care Plan
- More Review
- More Needs
- Care Package

**Flowchart**

1. Normally or Just Able
2. GOING
3. GOING
4. Waiting Game
5. Waiting Game
6. GOING
7. GONE
8. GONE
9.-disabled & Dependent

**Signs**

- GOING
- GONE
- Waiting Game
- GOING
- Waiting Game
- GOING
- GONE

**Locations**

- Into Hospital
- Ambulance
- A&E, MAU
- More Tests
The Debate

What do service users tell us they want from and value in, Intermediate Care?

There is already a considerable level of engagement underway in the development and delivery of IC services across Wales. All of the IC teams represented in the CoP incorporate service user feedback as part of the ongoing evaluation of their services, either through a formalised questionnaire or via reactive methods such as user stories, complaints and compliments.

Drawing on such feedback, the workshop participants identified the following as being important for service users:

- Responsiveness (not having to wait to see someone)
- Feeling safe and reducing anxiety
- Simplicity (don’t need or want to know how it works, when it does)
- Straightforward access to a service that does the job
- Knowing what’s going on, feeling involved in the care planning process
- Owning and contributing to the paperwork
- Making their own decisions and choices based on appropriate advice
- Information given in language they can understand
- Not being rushed
- Having a service that goes to them
- Clear communication (joined up professional response and signposting)
- Integrity (professionals who deliver on promises)
- Being valued as an individual (not having to ‘fit in a box’)
- Being treated with courtesy
- Not having their pride undermined
- Contact and company, maintaining social networks
- Consistent and co-ordinated (rather than fragmented services)
- Knowing that there will be clear goals and an end result
- The ability to hand over concerns to professionals when you need to
- Keeping independence and being enabled to stay at home
- Building a relationship with the IC team

How do we know this is what service users want?

Participants recognised the danger of professionals believing they know what service users want and acknowledged the need to ensure that those who deliver IC services regularly check that they are effectively meeting expectations. The following were identified as ways in which this can and is being achieved:

- Formal evaluation using satisfaction questionnaires, including the question ‘how can we improve the service?’
- Informal mechanisms including thank you cards, requests to come back, capturing verbal feedback in the form of user stories
- Engagement strategies eg using third sector and other existing forums
- Face to face interviews eg when undertaking formal project review (usually linked to funding requirements)
- Drawing on published research such as recent publications relating to older people
How do we reflect this knowledge in the day to day delivery of Intermediate Care services?

There was a consensus that incorporating this knowledge into day to day practice and demonstrating it through effective evaluation is challenging.

It was agreed that the focus on service user experience and outcomes requires a more sophisticated approach to evaluation than traditional methods such as those focussed on reducing average length of stay in hospital, bed days saved and short-term cost reduction.

Planning of services and the subsequent evaluation of them needs to focus on the outcomes desired by service users, and will inevitably be more qualitative in nature.

A more personalised approach may well, for example, lead to greater risk-taking if this is consistent with achieving the user’s own goals. There needs to be a balance struck between measurable outcomes, service flexibility and the avoidance of services constrained by too many rules, described as “criteria-itis”.

Participants felt that operationally IC evaluation needs to be proactive and real-time to be able to actively benefit users. Simply put, it means advocating an “old-fashioned technique” of talking to people (users, carers and other professionals) and gathering feedback throughout the episode of care to inform real and immediate improvement.

A number of teams shared the experience of using their regular multidisciplinary meetings to reflect on these conversations and to take timely and responsive action to improve practice.

What does the evidence tell us works and is this consistent with our experience in Wales?

The workshop discussed and examined some of the negative press and counter arguments to the development of IC services, for example:

- Intermediate care is just good old-fashioned geriatric medicine
- Is Intermediate Care ageist?
- Intermediate care is just a flawed substitute for rehabilitation
- Despite innumerable attempts to define it, intermediate care is still just indeterminate care

Whilst these comments were generally rejected, the group did accept that some aspects of IC delivery are not necessarily groundbreaking. For example participants felt that IC can be said
to be replacing what GPs and District Nurses used to do before those services were reformed. The strengths of IC ‘done well’ however, lie in the co-ordinated multidisciplinary and whole system response it offers.

When reflecting on the anecdote that “intermediate care is just a dressed up phrase for old fashioned community services”, there was a great deal of consensus. Community Services have traditionally been based around the operational management of services or facilities that happen to be based in the community whereas, the intermediate approach has a philosophy of care that moves the focus away from sustaining particular services and towards maximising independence for the individual.

Definitions

The CoP agreed that there would be little value in debating the various definitions of IC already available. Similar work has been undertaken by the Care Services Improvement Partnership’s Change Agent Team in England and by the Scottish Joint Improvement Team (JIT).

The paper’s they have produced were circulated and discussed, and there was a general agreement with the JIT approach of adopting a broad definition alongside the identification of key features of an IC service.

There are a range of definitions for IC in use and they have been refined and reworded considerably to suit the particular needs and views of each group that have done so. Overall some of these definitions do have a few very specific or unique points, but most of the accepted descriptions include common IC principles:

- Targeted at a client group, such as those people failing at home
- Based on holistic assessment of the individuals complete needs
- Planned around defined outcomes aimed at maximising independence
- Time limited or based on a set of measured interventions
- Delivered through multiprofessional and multiagency structures and systems

These basic principles have evolved as services have learned, developed and expanded. For example many original service specifications were based around a time limited intervention of 6 weeks.

However in practice some IC teams have developed greater flexibility recognising that many individuals need much less time while some others benefit significantly from an extended period of contact.

Rather than thinking in discreet terms of targeted groups and time limited service models, intermediate care undertakes a measured response that includes specific interventions to reach specific personalised goals. This is a better description for IC which distinguishes the approach from the universal provision of care, or looking after people in the long term, which is the role of mainstream primary health and social care models of service.

Key Features of Intermediate Care Services

The key features of IC identified by the JIT, the British Geriatric Society (BGS) and the Health and Social Care Advisory Service (HSCAS) are depicted in the table below:
What should Intermediate Care look like in Wales?

<table>
<thead>
<tr>
<th>JIT</th>
<th>BGS</th>
<th>HSCAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrated &amp; focused</td>
<td>• Integrated, multi agency working</td>
<td>• Holistically managed care (across agencies)</td>
</tr>
<tr>
<td>• Maximises independence</td>
<td>• Maximising independence</td>
<td>• Goal orientated</td>
</tr>
<tr>
<td>• Prevents unnecessary admission</td>
<td>• Avoid inappropriate admission</td>
<td>• Needs-based, as determined by comprehensive assessment</td>
</tr>
<tr>
<td>• Supports timely discharge</td>
<td>• Avoid prolonged hospital stay</td>
<td>• Person centred</td>
</tr>
<tr>
<td>• Targeted (complex &amp; transition)</td>
<td>• Targeted (frail elderly)</td>
<td></td>
</tr>
<tr>
<td>• Relevant to all adult groups</td>
<td>• Time limited</td>
<td></td>
</tr>
<tr>
<td>• Time limited &amp; focussed on need</td>
<td>• Based on holistic assessment</td>
<td></td>
</tr>
<tr>
<td>• Flexibility</td>
<td>• Not overly prescriptive</td>
<td></td>
</tr>
<tr>
<td>• Pathway connection to mainstream</td>
<td>• Linked to mainstream</td>
<td></td>
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</tbody>
</table>

Examples of IC services were identified as follows:

<table>
<thead>
<tr>
<th>JIT</th>
<th>BGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community assessment &amp; treatment teams</td>
<td>• Community assessment &amp; rehab schemes</td>
</tr>
<tr>
<td>• Joint community rehabilitation teams</td>
<td>• Stroke rehab outreach teams</td>
</tr>
<tr>
<td>• Rapid response services</td>
<td>• Rapid response services</td>
</tr>
<tr>
<td>• Intensive care at home services</td>
<td>• Hospital at Home schemes</td>
</tr>
<tr>
<td>• Extra care housing developments &amp; telecare developments</td>
<td>• Care home rehabilitation units</td>
</tr>
<tr>
<td>• Alternative use of care home provision</td>
<td>• Community hospitals</td>
</tr>
<tr>
<td>• Innovative use of community hospital facilities</td>
<td>• Nurse led units</td>
</tr>
<tr>
<td>• Extended primary care teams</td>
<td>• Day hospitals</td>
</tr>
<tr>
<td></td>
<td>• Hospital support discharge teams.</td>
</tr>
</tbody>
</table>

Many services such as these have already been developed or are in development across the UK. However, at the time of the debate participants could not identify any single locality or model of care which offers the full continuum of IC, across all its services.

It was also acknowledged that Local Authorities across the UK are actively developing a range of teams to deliver Reablement. Often based on a single point of contact these services are able to coordinate a rapid multidisciplinary assessment of needs prior to commissioning longer term care.

Similarly within Wales, the Social Services Improvement Agency is leading a national programme with Social Service Departments, to align these developments across Local Authorities with common standards for Reablement services. The group felt that this alignment
of services was a significant and important step in the long term process of integrating and mainstreaming the intermediate approach to care.

**Research Findings**

Recent research reviews by the BGS, Godfrey et al and the Nuffield Institute were examined and are referenced in Appendix 2. The findings were debated by the workshop and compared to the real-life experience of practitioners and managers in Wales.

**Day hospital care is as good as in patient comprehensive geriatric assessment but may be more expensive:**

There was little experience of this amongst participants, though the Elderly Care Assessment Service (ECAS) based at Rookwood Hospital in Cardiff was highlighted as a good example.

**Early transfer to Community Hospitals is associated with increased independence & is equally cost effective as acute hospital:**

There was general disagreement with this finding and indeed recent reviews undertaken by several organisations including NLIAH indicate that transfer to a community hospital in Wales can lead to an increased length of stay, reduced independence and greater risk of care home placement. The group acknowledged however, that this may be a result of how we tend push patients towards and make use of, our community hospitals. This research therefore requires further examination and must be considered in the light of the review of Primary and Community Care undertaken on behalf of the Welsh Assembly Government by Dr Chris Jones.

**Nurse led units are safe but lead to increased length of stay and are not cost-effective:**

Again, there was little experience of this amongst participants and the use of nurse-led units does not appear to be common in Wales. It is noted that a nurse-led Intensive Discharge Unit (IDU) is currently being piloted in ABMU NHS Trust.

**Hospital at Home is the best supported IC model: leading to increased patient satisfaction, increased carer strain, inconclusive evidence of cost effectiveness, improved outcomes and bed days for stroke recovery and exacerbation of COPD:**

It was noted that the majority of IC service development in Wales so far, has focussed on Reablement and Facilitated Early Discharge, and therefore experience of this type of service is limited.

Many areas are currently considering or developing admission avoidance schemes and it was acknowledged that some elements of these findings raise cause for concern. For example, the increased strain on carers needs to be considered in any ‘hospital at home’ type package and it has not been a key feature to date.

The research which highlighted a query regarding increased mortality rates for older people with medical conditions was open to criticism regarding sample size and methodology.
There was a consensus however, that this would need to be carefully monitored in any Welsh Hospital at Home type services and reinforces the need for robust clinical governance processes.

**Non residential IC services cost less than residential alternatives:**

This was not disputed as it appears self-evident and congruent with the overall philosophy for developing innovative and responsive service models away from traditional ‘bricks and mortar’.

**Service users rate quality of life gains higher following residential IC services:**

There was a mixed response to this finding. In some areas residential IC services have not proved popular with service users, whereas others have found the experience to be very positive. This may be due to the location and local arrangements for the specific services and it is suggested that this is an area for further investigation in Wales.

**Admission avoidance schemes are cheaper than those for facilitated discharge:**

It was agreed that this is also reasonable given that admission avoidance schemes tend to have a more specifically defined scope. For example, Rapid Response Teams that administer intravenous antibiotics at home have shorter episodes of care and focus on more proactive handovers back to mainstream services.

Plus teams designed to facilitate discharge have to deal with the additional complexities and problems caused by patients being held or delayed in a care environment not best suited to their needs.

**Quality of life gains are rated higher for admission avoidance schemes:**

The group did not feel there was sufficient experience or evidence to debate the issues at this stage, despite the perceived long term benefits to the individual of maintaining the activities of daily living and preserving contact with social networks.

**Recommendations from the Research**

The research makes a number of recommendations for the future development of IC services and the workshop debated; how far these were already being implemented in Wales; where they were not, did they need to be; and what are be the barriers to further development?

1 - **Develop closer integration between IC and ‘mainstream’ services**

The workshop agreed with this and acknowledged that it represents ‘a work in progress’ in Wales. Although, many areas have developed formalised interfaces between the services and report good links with District Nursing Services for example, it was recognised that the effectiveness of handovers has a significant bearing on maintaining independence over time.

The issue of personalised care plans was briefly mentioned. Whereby appropriate people identified as complex or at risk of failure, hold a copy of a long term care plan which is
accessible to any service provider who comes into contact with the person planned or otherwise. This is congruent with a range of developments in patient contracts, expert patients and carer coordinators.

Mental Health services were cited with good examples of a common culture and strong informal links between IC and primary care provision, though it was acknowledged that there were universal problems in the area of younger people and transition into adult services.

2 - Target patients with greatest clinical need

It was felt that this recommendation requires further examination and contextualisation. There are two areas of concern:

- If the emphasis is on providing ‘right care, in the right place, at the right time, by the right person’ then it has to be acknowledged that patients with the greatest clinical need may be better off with established secondary care intervention.
- If there is equal emphasis on enablement and promoting independence then it makes sense to intervene before people reach crisis point. Practitioners want to avoid the response provided to users being controlled by a narrow “clinical label”.

It may be that this recommendation is aimed primarily at providing a case management approach for people with long-term conditions rather than wider IC service users. The feeling was that this is a good example of the link between an IC intervention to provide fast track Rehabilitation and an ongoing personal plan of care managed by a GP.

3 - Place stronger focus on admission avoidance services (with further evaluation)

Whilst there was general agreement with this recommendation there is also a reluctance to put IC services in a silo. It could be said that admission avoidance schemes are in essence concentrating resources on a failure in the traditional medical model. IC is not just a method of avoiding admission to traditional services. Rather, it is felt that there is a clear opportunity in Wales for IC to be delivered as a whole system solution to providing the continuum of care. It was also felt that there needs to be a clear distinction between the aims and provision of residential IC services and activities such as care home placements.

It was acknowledged that IC services need to develop closer working relationships with sheltered housing and care home providers to ensure that they are supported in maintaining the health and wellbeing of residents and avoiding unnecessary admissions to secondary care.

4 - Develop strong clinical governance systems

There was clear agreement with this recommendation and the CoP were eager to undertake a discreet piece of work, with the support from external expertise, to develop a framework for clinical governance in IC services.
5 - IC services should have a strong presence in A&E

This recommendation was agreed (in terms of presence and relationships) and it was acknowledged that there is little evidence that this is currently happening in Wales. The CoP agreed to explore this aspect in greater detail and to include Ambulance Services. There were well known examples of broader multidisciplinary teams being established within in A&E to redirect, signpost and initiate alternatives to acute admission. Morriston Hospital in Swansea was sited as a good example of this development, although there is no formal IC involvement as yet.

6 - IC provision should include older people’s mental health services

It was agreed that older people with cognitive impairment and mental health needs can be excluded from many IC schemes. Further work will be required to adapt the services and skill up IC teams or enable joint access to the necessary expertise to provide a complete service. The group acknowledged that there is a significant increase in people with both physical health and mental health needs and current operational structures can run the risk of people receiving disjointed services or “all of one and none of the other”.

The projected increase in organic mental disorders as a consequence of the ageing population will have a significant impact on the integration of physical and mental health services, particularly around the provision of IC. The National Dementia Action plan for Wales also outlines many of these challenges. When combined with high levels of undiagnosed and untreated depression in older people, this will suggest that older people with physical health problems, not accompanied by a mental illness, will be the exception.

Crisis Resolution and Home Treatment Services have been developing as a priority and are a model for IC policy implementation guidance for Mental Health Services. This includes as a fundamental component, screening all potential admissions to hospital care. Where services have been effectively developed they have led to a reduction in admissions in the region of 30% and in associated reduction in lengths of stay in hospital. Some services have now developed Crisis Houses which are likely to increase these outcomes. This has allowed some resources to be redirected into the community setting to reinvest in further service development and reducing bed numbers.

The experience so far is that in some circumstances it can be challenging with clinicians frequently allied to more traditional models of care and the “security” of protected beds. Broadly, service users value these services where they work well and they provide, through ease of access, a good working relationship with GPs who want simplified access whilst managing more care within local communities. The developments do have challenges such as eligibility criteria and double running costs during establishment.

7. IC is a tool for accelerating health and social care integration

Experience within the CoP confirms that IC teams must be multidisciplinary by definition and in reality services are delivered by practitioners working in partnership across health and social care. The day to day way in which these services are provided, by teams comprising...
practitioners funded through health and practitioners funded through social care, has necessitated simple and effective ways of joint working being established.

In many cases, they have come to terms with the balancing act of meeting the needs of people accessing services and the need to deliver health and social care in a joined up and seamless way. IC services hold valuable learning having confronted the challenge of different policies, different information systems, competing governance requirements and misaligned management structures. This is a significant achievement when corporately their parent organisations are less able to work in this way.

Conclusions

It is evident that health and social care practitioners working in existing Intermediate Care Services across Wales are committed to providing a safe, effective and flexible range of services that are focussed on achieving what is important to their service users. Rehabilitation, Reablement and Facilitated Early Discharge services are reasonably well established across the country albeit with varying capacity. The development of other services in the continuum of care such as Acute Intervention and Hospital at Home, are still in relative infancy.

Overall the current state of IC development provides a clear opportunity for the IC CoP to work together to jointly problem solve and develop a consistency of approach across the country, whilst respecting and embracing the need for a 'local flavour'.

The adjacent diagram illustrates the traditional commissioning aims of intermediate care and some of the range of services that contribute to the achieving those aims. In reality when the service interventions are effectively aligned with the individual needs of the person, it’s not only possible to achieve those aims but also, to begin to generate a longer term impact for the wider community.

This model has been debated in a number of intermediate care events and participants have been invited to articulate what those longer term impacts could be. There has been a great deal of consensus that the future of Intermediate Care should rightly be focussed on maximising the opportunities for every person to be independent, happy and active within their chosen community.

Therefore, the potential impacts on those communities have been described as:

- **“A Measured Response”:** a widespread and clear understanding of what the intermediate approach can achieve with acceptance from the public in social marketing terms and recognition from service providers, that it forms an integral part of an effective continuum of care.

- **“An Early Contact”:** the ability for allied services and identified individuals to access intermediate care simply and when it’s needed, to firstly keep people independent at home or secondly, quickly and safely support people returning to their community.

- **“A Steady State”:** Ultimately if people are supported to maintain an active role in their chosen community, then the community is stronger and in turn, is more able to support the people within it and break the cycle of decline and dependence.
What should Intermediate Care look like in Wales?

Under the Umbrella

At present across Health and Social Care in Wales a substantial amount of expertise and resources are being committed to improving a complex set of competing priorities, including Reablement, Unscheduled Care, Chronic Conditions, Dementia, Patient Choice, Delayed Transfers of Care, Continuing NHS Healthcare and Financial Sustainability.

These priorities are in fact, either solutions to or symptoms of, the same set of problems. People across the spectrum of health and social care are becoming more complex and independent services are less and less able to fulfil their needs in isolation. A person’s care is neither holistic nor optimised and eventually they end up trapped inside expensive institutional services. If the focus for all these priorities is set on maximising independence in the long term, then the symptoms will reduce and the solutions are less critical.

In recognising that Intermediate Care is the umbrella under which many complementary services are working on maximising independence, it becomes clear that the umbrella will have a significant effect on the modernisation and future development of services in the community.

Subsequently alongside developing new and improved models of service, the Intermediate Approach provides a viable and widely acceptable philosophy of care to align and integrate key priorities and services.

So What …

The aim of this discussion paper is to stimulate the national debate on the development of Intermediate Care and raise the profile of the issues confronted by service providers and users across Wales. The adjacent diagram represents the building blocks necessary to develop a light and focussed Strategy for Intermediate Care, based upon and utilising, the extensive knowledge and experience currently within the system in Wales.

The five outer elements are very broad titles that describe the work to do and together, they form an ongoing cycle of continuous improvement.

The inner ring represents the stakeholders and is rotated to reflect which elements of the work that each group has greatest impact upon.

The centre circle is the emergent strategy which will emphasise the responsive and person centred principles that will unite the stakeholders and drive the work.

In May 2009 the Wales Audit Office published the 'Delayed Transfers of Care Follow-Through Report' citing the Community of Practice and espousing the value of intermediate care services in developing a long term solution to DTOC within Wales.
What should Intermediate Care look like in Wales?

This discussion paper sits firmly within the ‘Learning’ element of the work and the CoP is eager to extend an honest and challenging debate to share what has already been learnt within Intermediate Care.

It is hoped the CoP will forge links with more people interested in the intermediate approach to care and generate the mandate and commitment to undertake the necessary work and help towards developing a joint strategy for Wales.

Ongoing areas of work identified from the workshop debate include:

- Further examination of residential IC services that CoP members report as being well utilised and received by service users, to identify the key success factors
- The development of mechanisms to support carers of individuals receiving Hospital at Home type services
- The development of a robust and joint national Clinical Governance framework for IC services in Wales
- Greater involvement of the health sector in the ongoing design and development of the Reablement model of services
- Identification of those areas in Wales where there is a strong IC presence in A&E departments and collation of the evidence of their effectiveness
- Monitoring of those schemes that do not exclude older people with mental health problems and identification of the core skills and competencies required to deliver effective IC to this client group

NLIAH is planning a series of Intermediate Care Roadshows around Wales to stimulate a professional and clinical debate focussed on the emerging models of care. If you would like to comment on this paper or contribute to the development of Intermediate Care in Wales, please contact the Change Agent Team as detailed in Appendix 2.

All contributions will be gratefully accepted so either forward your views in writing or, even better, contribute in person and book a place at the next Intermediate Care Roadshow or Intermediate Care Community of Practice Meeting.

Addendum

The Community of Practice is a diverse network of practitioners and managers, open to people with any level of experience and from any profession or sector in Wales, who share an interest in Intermediate Care.

The aim is to create space for people to learn, work and develop together to take collective advantage of their individual talent and experience.

The Change Agent Team organises and facilitates the CoP network and quarterly meetings however, the agenda and subsequent programme of work, is controlled and directed by the participants.

Many CoP members are active contributors while others maintain a more virtual role. If you would like to receive notice of meetings, or regular updates and information about Intermediate Care and the ongoing work of the Community of Practice, please join the network by emailing a request to cat@nliah.wales.nhs.uk.
Appendix 1

Supporting Practice in Intermediate Care Evaluation

Evaluating IC services requires a more sophisticated approach than most existing quantitative systems were designed to achieve.

Subsequently, across the UK existing evaluation is variable, sporadic and often designed around demonstrating achieved throughput as a return on investment, rather than qualitative outcomes for the service users. Whereas many reviews and published research contain compelling evidence, there is as yet, no coordinated or systematised approach to aggregating the information at a strategic level.

The SPICE programme was developed in 2007 through a CoP and involved several existing IC teams piloting an evaluation tool. The SPICE tool is essentially a very simple, web-based data collection device that captures anonymous information on; the condition of the service user on referral and discharge; and the interventions of the IC team.

Use of the tool is voluntary and free of charge and includes data analysis software that provides practical, real-time reports and feedback.

At present a small number of IC teams are using SPICE and several other services have expressed an interest in uploading data from their existing systems into SPICE to contribute to the developing evidence base.

It is clear from the work within SPICE and at the IC CoP debate, that further development in evaluating services is essential. In a complex and evolving service, establishing the evidence base for continuous improvement will be critical to ongoing success.

Further information is available from the Change Agent Team detailed in Appendix 2.
Appendix 2

References

Intermediate Care: Guidance for Commissioners and Providers of Health and Social Care

Godfrey M, Keen J, Hardy B, Townsend J, Moore J, Ware T, West R & Weatherly H (2005)
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Intermediate Care- Agreeing a Common Definition

Leicester Nuffield Research Unit (2008)
'A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People: Executive Summary’
http://www.hs.le.ac.uk/nccsu/indexa.html
(click on publications then LNRU working papers)

Further reading:
Nancarrow S (2007)
The impact of intermediate care services on job satisfaction, skills and career development opportunities.
Journal of Clinical Nursing 16, 1222-1229

Organisation and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge.

Further information on this discussion paper and the development of Intermediate Care is available by contacting the Change Agent Team:

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