



'Everybody wants it, it's just getting there' Intermediate care

Introduction and context This story is about Intermediate Care (IC) provided to clients/ service users to support them when they come out of hospital, or to prevent admission. It is free to all and lasts around 6 weeks only. It is jointly managed by the local authority Social and Community Services (SCS) Department and 5 PCTs.

The Intermediate Care manager's remit was to integrate three existing services: These services were:



The Rapid Response Re-enablement Service (RRR) funded by Social and Community Services, and aiming to 're-enable' patients /clients in their own homes.

Intensive Community Support Services (ICSS), a nursing service to offer care and provide care in the homes, sometimes to people lat the end of their life.

The Community Rehabilitation Service (CRS), jointly employed by Health, and Social and Community Services, who are Occupational and Physiotherapists. They work both in people's homes and in day and community hospitals. The aim is that each person is provided with the support they need from any of these services, in an integrated way. This phase of IC follows from government directives in the NHS plan ,the NSF for older people

In this county however, the struggle to create a coherent integrated care service has been going on since 1996, through many different 'morphs' [Amanda]. The context is one of many different phases of restructuring, and the integration must now be carried out at 'nil cost' [Katie].

People in this case

[Mrs S and Mr and Mrs A](#) - clients/users of Intermediate Care

[Valerie:](#) Intermediate Care provider, S& CS

[Edwina](#) - locality team manager for Intermediate Care, S& CS

[Imogen](#) - locality team manager (joint post between PCT and S & CS; a therapist by profession)

[Brenda](#) - Service manager for Intermediate Care, S & CS

[Amanda](#) - Service manager, Intermediate Care, PCT

[Katie](#) - Intermediate Care Manager, jointly employed, one of three in each area who make up 'the mix'

[Issues in these stories](#)

The experience of a 'Rapid Response' service user 'Mrs S'

I had a fall in my kitchen in January and cracked my pelvis. I was in the hospital for two weeks. The second week I was waiting for arrangements to be made for Rapid Response carers.

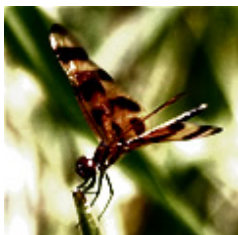
It was very painful. I had my bed down here and a commode. I don't remember who provided me with the aids. The OT and the physio came. They contacted my daughter, she did a lot of the organising with them. They were very busy.

Once I was back home, the carers came twice a day. I don't know their names. They were on a rota. They were marvellous. They came between 7 and 8 in the morning. I like to get myself up and washed. I got my breakfast. They'd make coffee.

They were so good. I was so determined. They made my bed and gave me my tablets. There wasn't a lot they could do - they were here for about 10 minutes, I had a key box. They let themselves in with a pin number. I could cope with cooking - I had a friend's microwave. Either my friend L. or my daughter did my shopping. The carers came in the evening to see I was alright, or if I wanted a drink. They didn't have to do very much. Isn't it funny you can't remember pain?

Unfortunately, my other leg was affected; it swelled and got more painful. Eventually, I had the doctor come, he had a look. He thought I ought to go back into hospital. I went back to the hospital but they were short of beds. The Registrar came and to tell me, would I mind being moved? I went to St. L's, a private hospital, I didn't have to pay. Sheer luxury - my own room, telephone, toilet, washing.

The NHS hospital was very good. - the care I got there.



The time went by. I was waiting about a week. The second time the OT and the physio taught me how to get upstairs, the carers helped me practise, watched me go upstairs. I was longing to sleep in my own bed. They made sure I could cope with the tablets. I didn't go out for 2 ½ months altogether. They would have gone out with me, but I went out

with my friend. I was a bit uncertain, but I soon got going.

I haven't got any pain - completely back to normal. . It was a very painful fracture, I was very determined. I can't see faces; I have to guess by the voice. I've nothing but gratitude for them.

The experience of a 'Rapid Response' service user and his wife Mr. A

Mr A had a brain tumour which incapacitated his leg and his right arm. He was taken into an acute hospital in the big town, where he stayed a month.

Mrs. A tells this part of the story:

"When he came out, he was home for a fortnight. There was no help at all. I was only given a commode. He was paralysed all down the right side. It was terrible. No-one came to visit. At the hospital they helped me get him in the car once, to see if he could. Then they left me to it."

Then Mr. A had a terrible pain, was rushed into the local hospital, where they found he had a perforated colon. He had an urgent operation. Now he uses a colostomy.

Mr. A:

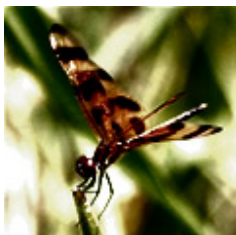
"They [the Rapid Response people] came to see me in hospital and decided to take me on. The day I came out of hospital they came in the evening. They helped with washing, personal bits and pieces, exercises, lifting me out of bed with a hoist. They came in twice a day, sometimes three times to help with the exercises if they were in the area. To start with there were half a dozen. We got to know them very well. Then with the new system it could be one of a dozen. It wasn't as good as the close-knit lot. They always introduce themselves - they used to ring up say so-and-so is coming out to see you.

I couldn't fault them their care and attention. They came for 8-9 weeks. They persuaded me to go to the community hospital for physio.

I couldn't praise them enough. My wife couldn't have managed with out them. I was bedridden for 3 months.

Mrs. A:

"They were absolutely brilliant. If they came and it was an 'off' morning, which happened quite often at he beginning, by the time they left they had made my day for me more than once. They had a cup of tea with us and a chat. There were always on the end of the phone.



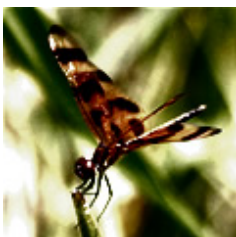
While he was in hospital the first time, I had a stairlift and a wet floor shower put in. It cost just under £6000. We were told we could apply for a grant but it would take 6 months and we might not get it. He came home on 22 November. Our aim was to get him upstairs by Christmas, so we could spend Christmas night upstairs in bed together.

The Rapid Response did all the exercises with him. He was upstairs 10 days before Christmas. It was wonderful I couldn't believe it."

Valerie, Intermediate Care Provider, Social and Community Services: Getting them back to independence

We go into the clients' homes and help with any re-enablement that the physios [physiotherapists] and OTs [occupational therapists] decide on and also social re-enablement to help them regain confidence, and get them back to independence.

It might be a stroke or a hip replacement or in one case we had a lady who was run over. It's actually to get them back to as near independent as they were before, whether it's physio exercises or just building their confidence, getting them out, getting on and off a bus because it was a bus that hit her. We don't do much for them in the way of personal care. There is another service for that, the Home Support Service. Ours is short term, up to 6 weeks; we can extend it but it doesn't happen very often.



We have an IC [Intermediate Care] desk downstairs that all referrals go into. Any one can refer: a relative, a GP, the person themselves- but that's mainly for equipment. We have to have a care manager. Usually they are planned hospital discharges. In the hospital we have worked with the physios and OTs, but we very rarely work with the referrers- because it could be a staff nurse, and obviously their shifts are different. The orthopaedic consultant refers the lady to the IC desk, 3 people work on that. It's manned Monday to Friday- they are clinicians, could be anything. I wouldn't call myself a clinician. I am in one sense. In another I'm just a provider of care. The appropriate forms would be filled out. We update them daily according to the availability we have. We are part of Social and Community Services and we work for the local authority. The IC people work for the health service. We don't work by boundaries like the PCT at the moment - we will do, at the moment our boundaries are different from theirs.

We will be integrated

They have teams the same as ours in the other areas. We meet together: our care managers, the IC desk, the physios, OTs and we do have a designated nurse now. We will be integrated - by that I mean we are all put in the same building. Our team - we have been here 3 years, the other teams have been coming in over the last 6 months - the OTs (two of them) and the physios (four of them) - the health people. They're not all in this building, but it is early days yet. We know who they are and how to get hold of them, though they are not close by.

We have three levels of management. There are 18 care providers, and we have a team manager who looks out for us. We have a unit manager who oversees all of us - care providers and the health. She's a locality manager. She comes from health, she's actually a nurse. Above her you've got X. She oversees us and the other 2 localities.

Our side of it has been going to longer than three years - we used to be called Rapid



Response. That's been going for 6-7 years. That was just us - that means the local authority. We had access to physios outside of our particular bit, but we had to join the waiting list like anyone else, which isn't conducive to a short term service. We would go into someone's home, and sometimes we would finish [the whole period of working with them] before the physio got there. 'Rapid response' became IC this year. It hasn't changed that much for us, because our job hasn't changed, but the amount of people around us has. We have now designated care managers, so we can get the information and packages moving, we have OTs and physios and we have equipment. We don't have CRS [Community Rehabilitation Services] and ICS [Intensive Community Care Services]. They will become part of us - it is in the south but not here yet... That means you can provide a wider range of services for people.

We were the poor relation

It's been better for us. We were the poor relation out on a limb here. We did not have all these other services. We had to make half a dozen phone calls. We did not know the people. We could deal with 2-3 PCTs at any one time, so we never got to meet them. We cross boundaries but it is being looked at. They've got decide how.

If we are inundated we pass it to our managers. If not, we make the phone calls and make weekly reports. We bring in the physios. Priorities ? - it's not difficult. If we are going in, we do the first assessment, we submit the referral form and someone will go out from the CRS team - that's physios and OTs, and assess them. They will get whatever equipment we need, they decide. You'll say what's needed. It's up to them whether it's a physio or an OT, although we know - we've done it so many times. A physio works on muscles, an OT works on the aids and equipment to ease the process.

Us and the care manager - we are the main contact with relatives. The care manager works for us, the care manager is the purchaser of care, they are usually social workers. There are 2 care managers.

We do the Single Assessment Process - the care manager and one of us usually. Everything is discussed with the service user on a weekly basis, what they feel or what we feel. We spend however long they need us - not half a day, but an hour is not unreasonable.

A day's work

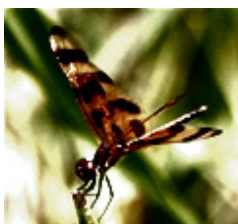
You come in, you see the work for the day. We are not a timed service; no one is expecting us at a particular time. You go to one client, you do the various therapies, whether it's speech therapy, or physio with them. This particular lady I took up to the post office because of her condition, she's lost her confidence outside of the house speaking with people. We can understand what she is saying, even though other people can't. You re-introduce her back into her community. She was a volunteer worker for several charities. We were mostly working on the speech and her confidence. Then I would go to another

client - that was actually a knee replacement, she's got a fitted brace, we would do her exercises with her then we would go for a walk to strengthen her leg muscles. The next lady was in a halo because she had broken her neck. We would help with personal care, because she can't bend her head. But she would do whatever she could do, and we were there as a support. We do do lunches, but we advocate them cooking for themselves and we stand alongside them. I went to someone else at lunchtime, it was lady that had broken her hip. I don't like to use the word teaching, but she had never used a microwave, so I was showing her how to use it. Then we come back to the office and we do our records, we have a whole cupboard of client files. It's on a special form, but they're not on the computer, we write them. We're behind the times. There are 2 shifts between 7 in the morning and 10 at night. We have a handover about half past two - any changes.

We don't relate to Home Care - we are totally separate from Home Care. If we have taken on a client and there is no re-enablement, we then refer them to Home Support. Other than that the two don't generally meet. It's either us or them- there are criteria.

This is very different

Most of us were with Social services as Home Support. This is very different. We do more to encourage them to be independent, we have more time, and we do an awful lot more paper work. We do client records in the home, and here. We do the weekly reviews to the care managers, we deal with any district nurses or physios that need to be informed. We are given time to do that. I prefer this. It's a different kind of skill. We have a communication book in the home, so a GP or a physio, they don't see our records in the office. The others have their own records. It's still separate. They come together on a weekly review form. We tell them what we've done and they tell us - all by hand. We fax off the piece of paper.



Sometimes it may be that a speech therapist has been and come up with a different set of therapies to do the following week, if they haven't written in our book and we don't know they've been, then we could carry on doing the last week's. That doesn't happen very often now. I had done speech therapies before, and also a couple of us went to the hospital to see the speech therapist. There are exercises for the mouth. There is a bog standard set of exercises, you never do anything without the client being assessed first.

You do see changes - I had a conversation over the phone with the woman who had not been able to speak. I could understand every word.

I've done lots of things before. We do have re-enablement training, when we are integrated

we will also come under the health training which hasn't started yet. We do NVQ 3 in social care - I do NVQ assessing. I love that side of it.

Edwina: Intermediate Care locality team manager, Social and Community Services Life is full of anomalies

Being a locality is a big strength because there is a strong sense of identity and patient/client care is local. However, staff are on different sites- and there are disparities, because colleagues are managing different numbers of staff on different sites. I manage 60 people and all the services and it seems that a similar job with similar pay but about 1/3 of the size is seen as being equal -it's a built in irritation.

In April last year, three separate services merged to become the integrated Intermediate Care services for localities. Consultation took place purely for the managers of the service - it was specifically relevant for people who would lose their jobs - it was supposed to be a cost neutral exercise but managers needed to be made redundant in two of the services. My role was at social services management pay rate, which is higher than colleagues in health. The consultation was not about the operational side of things but on the management structure. Everyone agreed with that, even though funding was not clear. In principle integration was agreed on as the best for the patient and client.



People pay lip service

Clinical accountability is seen as difficult issue - professional clinical lead and supervision were scrubbed. It was promised that there would be two parallel lines where there were managers - clinical and operational. As a social service manager I cannot clinically manage occupational therapists, nurses etc. That was accepted in theory so that there would be different managers employed to have a physiotherapy lead, occupational therapy lead etc - so I had someone who knows what they are doing because I don't, leads would make sure that staff are competent, efficient and confident and have appraisals done and there are proper inductions for new staff. That has failed to materialize. There are two reasons - no money was ever given for it, still do not know why not - secondly the senior nurses and therapists were playing silly buggers when there was disagreement between them. It's very clinically vulnerable : a mistake could occur, and if we were sued we would be in a huge amount of trouble. People pay lip service to it - senior managers cross the 't's and dot the 'i's - but

operational staff are left to get on with it.

Avoiding the alligators

After the consultation my job description was huge - ridiculous; human resources said it would be unworkable. I can grasp what to do with social service staff which affects 1/3 of my staff, 2/3 are health but now I am expected to understand all the policies and procedures - how to recruit - I am doing 2 jobs with 1 person - I do what I can day to day - some jobs get done and others have to wait. The term 'swampy ground' is a good description - one is struggling - jumping from one solid lump to another lump avoiding the alligators - we are struggling knee deep - probably will get more difficult.

Intermediate care is flavour of the month, because health authority and social services are very keen on meeting their performance indicators. Social Services want to reduce late discharges from the acute hospital by getting them into Intermediate Care not community hospitals - there is a big pressure on a quick turn round around. The DoH asks for performance indicators from us which is where we get star ratings and on which we get money. I have a suspicion that we will be expected to keep up with a certain level of performance indicators while we are still struggling to integrate.

This hits the care providers because [some are] employed by health and [some] by social services - they need to move together into one room to work together. They have separate team meetings. Social services people say they feel they are being taken over by health and health say they are being taken over by social services - so that's about right - they do work differently - with different remits. In the big scheme of things we will have a generic worker, who will have to be able to work in rehabilitation for outdoor mobility down to other end of spectrum to work under a nurse caring for a terminally ill person. There are a lot of rumours - change at the sharp end. One group says they are all going to leave. There is lots of anxiety and difficulty and so trying to change it slowly - it will take time and how much time we will be given by managers I don't know.

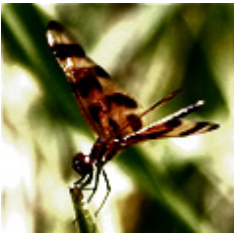
Looking back at [strategy], we have had a fudge - no clear decision, with a foot in both camps. It would have been better to have either health or social services take it over. A lot of us were resistant to that but it is difficult having both social services and health : being one or other would have been easier. It all seems to be pragmatic solutions rather than thinking it through properly. As an operational manager I have to come up with pragmatic solutions to take staff along with me - the key is to delegate service responsibility, to have a person for each area of service and hospital who can make decisions.

From client or patient viewpoint it does make sense

It is sensible when a referral comes in, instead of sending it onto one of 3 directions - therapist, day hospital and care services - duplication will cease - they will all be part of

integrated services -there will be one assessment - the person will have a service which moves closer and quickly . This single assessment is one of the key issues - therapist numbers have not been increased - clinical time will still have to be taken up - we have lost clinical tasks and have less capacity but demand will increase so there are pressures building up but there will not be the staff. There is an assumption that it will be an improvement for the user - there is no research to prove that - lip service is paid to that and that all that is important is meeting performance indicators and getting quick discharges from hospitals.

We have different data bases - there are working parties trying to resolve issues. I would not have a clue how constant and efficient the different services are - I do not have time to keep an eye on all of them - so getting information to see if we are meeting key performance indicators on getting patients through the system is difficult. It will be a nightmare if we do not get a shared data base soon. Some people have to give the same information to 2 different data bases even if people are working in same place. But the system cannot be accessed by health employees. Different performance indicators are being measured. Half of my team will have to be trained to use the social services data base, which will take away from clinical time which means they definitely will not meet performance indicators. Then there are several different paper systems.



We are still knee deep in the swamp

Issues related to pay have always been around and it is now more contentious - managers are paid differently- that was not new and of course budgets for health are tight because of overspend. There are health employees' meetings and then another for social service staff because of separate budgets. We are still knee deep in the swamp - and likely to be for a long while with a feeling that we have not been given the tools to do what we are expected to do. It is quite difficult when staff are saying we were promised that this would happen but teams are still not integrated - I am fortunate that staff are on one site . Operational staff think when things are agreed then it will happen within weeks not months or rather years - things are moving forward - things have not been done well at all should have been thought through - it's left resentment and difficulties - maybe that's a pessimistic view - but I think its realistic at ground level.

I have a helpful manager who is reassuring. She does not expect much progress in the short term. Staff generally want to get on and get there is good will left - one firm boulder left - few and far between though.

Imogen- Locality Team Manager (joint post between PCT and Social and Community Services; a therapist by profession)

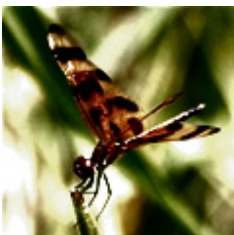
Therapists worked really hard to maintain services We moved into fully integrated teams this year having been through tremendous change over the last three years. Physios, speech and language and occupational therapists were employed by the community trust, then 5 years ago PCTs were formed but we remained a county wide service across all the PCTs. When PCTs [were restructured], we remained across the county and we worked across all areas but hosted by individual PCTs. Therapy managers lost their posts when the county service was disbanded and for a year therapists were being looked after by new managers of Intermediate Care. Then we were in limbo for a year till we moved into fully integrated teams - the higher levels were upset but on the ground the service remained the same - there was conflict between managers.

Therapists worked really hard to maintain the service to the clients. But this April we became fully integrated and we moved to being 'multi professional' managers - no longer use 'professional' we are now 'multi - professional' managers - so that staff included carers, social and community staff and therapists - it's working well. These teams have been in existence before but now they are pulled together with one manager over them.

We are feeling our way at the moment

On the ground we work very, very well in partnership. But there are huge issues between social care staff and community and PCT staff. There is discrepancy in pay which is acknowledged at national level but there is not a commitment to change things at ground level - this affects all staff. Staff put it to the side but care staff may be sitting next to each other and being paid differently. It's about how people perceive themselves, how they are valued. I was brought in as a joint post between the PCT and social and community services. I get paid by the PCT which is less than a colleague who works in the same post with Social and Community Services. The money comes out of the same pot - so there is no excuse for the discrepancy.

Also with performance measures - health and PCT staff in the community have not got the plethora of performance indicators that Social and Community Services have. The two organisations expect different things from staff and run things differently and what they expect from their staff is different and we are trying to get our heads around that at the moment.



It's like with IT- health staff do not have same access to it as social and community services - the funding stream is different for social community services. It would be nice to meet in the middle somewhere

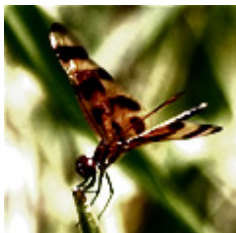
Another irritating fact is that we are not in same building to work together - members of team do not sit together - so in theory we are integrated but some of the teams do not sit together. On paper it looks good but in practice it is slightly different and there is no money from health to help co-location. People only have to travel short distances to get together but care teams need to sit together, not to be a mile apart, to have integration. The partnerships we work with are PCT health staff, voluntary sector, user groups and district councils. I have 60 people in my team - communication is my number one priority so we have a steering group meeting each week and then members of the team feed down to their staff.

Social and Community Services cannot sneeze before filling in a form: they are more robust whereas health and PCT land are more free and easy. I am not saying one way is better than the other. Health refers to 'patients', social services to 'clients'. Health is free, for some social and community services people are means tested - for our intermediate care there is no charge. All this is affecting integration.

Eligibility criteria are different between the two organizations - we are working to bring these together which will help. There are now joint health and community service therapists, both pick up an 'end of life' referral at any age - there is no difference in age now, there used to be.

Care staff are finding it difficult

The care staff are finding it the most difficult - there are huge expectations of them - the Re-enablement and Rapid Response teams had clients referred to them, they were cherry picked as being the ones who would improve very quickly with the input from the team. The health care team used to pick up a lot of 'end of life' work: they were more caring and worked closely with district nurses. These two teams have been brought together now. Some staff have never worked with 'end of life' people and do not want to do this work. People's jobs have changed and they are expected to do jobs that they did not apply for. So there are training needs and the care staff are finding it more difficult I think. Therapists have always worked with across all types of client or patient. Care staff need training - there are huge expectations of them - if they are expected to change their role - there is a need for a training analysis. This is just the beginning - we have an awful lot of work to do



This is not new. Everyone thinks integration is new but it's not new on the ground. But there is a need for a proper strategic lead with an analysis of training needs. There seems to be a gap - no leadership from the top - as a middle manager there is quite a lot of conflict and it is hard. There is no way of feeding to top, a huge cost cutting

exercise is going on. It's difficult as a middle manager- I am dealing with vacancies and appraisals----- and yet having to cut costs.

It's 8 weeks in so its early days. It is the way forward, there is a commitment to it. I'm not aware of any people who do not want to work together - we have worked together before: it makes sense for the patients and clients.

Brenda: Service Manager: Social and Community Services, Local Authority

I am service manager in the south of the county for Social and Community Services. I've got responsibility for managing operational teams which include specialist teams for older people and the assessment team which provides the front door services. We jointly manage the Intermediate Care (IC) service in the south. That means joint management between health and in Social and Community Services. I manage the OT service and the physical disability specialist service. I've got lead responsibility for physical disability services, and by default and more recently by design I will take on the IC service. I am an occupational therapist. I have been involved since before the service became integrated- 3-4 years ago. **The relationship with the PCT colleagues** - I have been really lucky. They are a very keen group of managers. I would be as honest with them as with you.



Two teams: Community Rehabilitation Service and Rapid Response Re-enablement

Before I became involved, about 4-5 years ago, one of our colleagues in Social Services at that time was given the task of setting up what we called Community Rehabilitation Services, on the back of government directives and new funding streams. The service manager worked closely with Health to look at what was needed. The new service was made up of physios and OTs and therapy assistants who were support workers to work with people in their own homes who were overseen by the therapists. It was quite a small service. It has grown over the last 2-3 years as new funding has come on-stream. Outside this, a specialist Home Support service run by Social and Community Service which we called Rapid Response and Re-enablement which sat under Home Support. It was managed separately. RRR we called it. The term 're-enablement' was about recognising we needed to do something different with our Home Support service. We didn't feel we could call it rehabilitation packages- there was no active involvement from therapists. We wanted care workers to work in an enabling way. We spent a lot of time working out if 're-enablement' was an actual word. We invented it here. So there were those 2 services managed within Social and Community Services. The

RRR-enablement -they were purely social work staff. The Community Rehabilitation Services brought together these newly funded posts plus the therapists from the health service in each locality. We didn't employ physios, Health put them in. We felt we didn't have a management structure to support them but we do employ OTs. There was a coordinator appointed for each of the localities by Social and Community Services.

The RRR service was set up separately at the same time. Even at that time we were saying, why are we doing it separately? It caused peculiar overlaps between RRR support workers and the Rehab assistants. Their roles were very similar but they were run quite separately.

A third service: Intensive Community Support Service

The other bit of the service developed within Health was Intensive Community Support Service, called ICSS, made up of nursing auxiliary type care workers and nursing staff and therapists. You can see there are real overlaps again. S and CS put quite a lot of funding into that. A lot of our staff were TUPEd over to Health to get that service going. It was started in pockets. There wasn't a consistent service across the county, to compensate for some areas not having community hospitals. The idea was to prevent admissions to hospital and to get people out earlier, as they would have nursing help at home. They would take people who had less stable health needs. That was managed by Health.

Overlaps

There were lots of discussions about bringing three services together because of the overlaps and what we all recognised was we couldn't prioritise the use of services to people who were actually needed them. If you had someone in an acute bed, they would ring round all the services to see where there was capacity. It might be just be default that someone ended up in one particular service. You would be wasting some of the nursing services.

'The mix':

this is where we wanted to get to a few years ago. It was agreed we should work towards the integration of Intermediate Care. Did we mean joint management, or single management, or a Section 31 agreement. We decided we would go for joint management in the first instance. There were a lot of fears from staff: are we going to be taken over by Health/by Community Services? What will that mean for mean as a professional? Does Health know about my professional area and vice versa?

We introduced 3 managers for the IC service new posts - they call themselves the 'mix'.

We've CRS, RRR and ICSS in each area, managed jointly. This is where we wanted to get to a few years ago. We've been through formal consultations September to November last year. That led to the appointment of the locality managers in February, then the fully integrated service started on 1 April this year.

Unions - it was very helpful to have them involved

The unions were all involved, challenging or supportive at different times. It was very helpful to have them involved. We had very recently gone through a therapy review, that was a very very painful experience. We learnt a lot from that.



What we learnt

- how we communicate, constantly giving information, we set aside a huge amount of time to meet with different staff groups, big consultation meetings, smaller team meetings. We gave regular feedback of what was coming out of those consultation meetings and where we thought the structure needed to go. People could feedback against that. We went to consultation with the formal joint management agreement. We said, this is what we think the service will look like; you will be managed by this sort of person You will keep your terms and conditions. Making sure that people were clear about what was up for consultation and what was not. Some of the therapists who went through it again tipped in some of their angst into this consultation. It was quite helpful - we could anticipate the sorts of questions, the same sort as previously. We had an idea of the sorts of answers we needed to give. Sometimes it was saying some things aren't up for negotiation.

Different pay and conditions

One of the barriers we've got sets of workers employed by two organisations with different pay and conditions, some of whom are doing the same job. One of the questions we were asked - are you going to combine them? We know it is a national problem. What we've had to say was, look, we can't solve this on own. There is a national debate about this. We will move into the integrated structure with people taking their existing pay and conditions. We will work with whatever opportunity there is to make that feel better. That will continue- at every staff meeting I go to.

Both our HR groups did some work together to show what the other benefits are in terms of leave, pensions etc. There are pay- offs. Social & Community staff tend to be on slightly higher salaries, but Health have better pensions and leave. The HR departments worked with us very closely through the consultations. The previous consultation with therapists was because previously there was a county structure with a professional lead head for OT and for Physio, when we had a community trust. Then we split into 5 PCTs and the aim was to put therapists into their localities. We are now moving to one PCT. So we are almost back to where we started.

Integration -what does that mean?

This happened alongside a whole load of other changes - everyone is swamped with change management, from practitioners to managers. Everyone said we should be working in an

integrated way but what did that mean? Should we have a Social Care Trust? Or join the PCT? On the S & CS side, there was a fear that the social care agenda would be lost. We are looking at joint management and integrated teams; that can happen in a number of different ways. There is different arrangement in Mental Health and again in Learning Disability. They are all at different stages in their integration, all very recent. The HR people from Learning Disability helped us with putting together the appointment process for joint managers.



The 3 locality managers all approach the jobs in a different way. Katie is from S & CS, the others are Health. We rely on them to use their strengths. For example, we've got data collection issues. We've got completely separate Performance Indicator systems. Katie is very familiar with them, keen and quick and able. It's much harder for the Health colleagues - don't have background. They're not familiar with our recording systems. The PIs come from S& CS. The challenge is to get the integrated service to own them. Health staff will be putting data into a system that they don't own, that they have never had to do. For example, assessment end times, start times, are reviews happening, indicators around statement of needs - Health did not collect all this information. I have to say to them, I want you to do all this extra activity on these indicators, which is not theirs to own.

'I didn't realise we were integrating our service' (senior manager)

Over 3 to 4 years, we've moved from a Community trust to 5 PCTs to 3 PCTs to one PCT - there are constant changes in senior managers. We have discussions about integration. The senior manager changes. I get faced with : 'I did not realise we were integrating our service.' I think, I've had this discussion with 2 or 3 other senior managers, we've agreed it. Sometimes you feel like you are starting again.



Wrangles about funding

Because both our organisations are financially challenged, we have to make savings separately. We're working to a section 31 agreement: all our money goes in one pot. Sometimes it feels that as fast as we were putting money into fund a therapy post, they were pulling money out for efficiency savings. Sometimes there isn't even a dialogue about it. I am suddenly told by Katie - were you aware that post is being pulled? Pressures to make savings - you have to do it.

Provider/commissioner split

Lots of anxiety about what will that mean for our staff, if there is privatisation. AT least

50% of staff are from S & CS. For home support, our members are looking closely at costs internally and delivered externally. One paper, it looks as if it is a more expensive to deliver in house than through external contracts. But that doesn't include contract monitoring and procurement.

Amanda: PCT manager, Intermediate Care 'Very closely involved in an inter-disciplinary model of working'

I have been involved in Intermediate Care since 1996. I started as a physiotherapist with a job in two community hospitals, across both ward settings and day hospitals. We had an opportunity for more meaningful rehabilitation and better patient outcomes, if we did a little bit of creative cheating. We started to do some outreach into people's homes. We were lucky because a nursing model was being developed with a particular focus on patient-centred and holistic services and that did give us a way in. I went on to be the superintendant leading the rehabilitation team of physiotherapists, very closely involved in an inter-disciplinary model of working, with the same patient records, and core multi-professional standards that were patient centred. At the time we had hospital care managers [from Social Services], but in one of the sad cuts in 1998 they withdrew the hospital care managers.

As I was looking for my own development, I was given the responsibility for developing the bid and the service description for domiciliary physiotherapy to contribute to a multi-professional services for patients at home. It wasn't called Intermediate Care; it was known as community rehabilitation. That was in 1998. The proposal was an excellent piece of collaborative work between social services and the old community trust.

In terms of behaviours and collaborative working, staff networked very closely but they weren't within a single structure. Is integrated working a management structure or a behaviour? Some very fine integrated work was achieved with people working in their own organisation. That did cause some challenges because of the different expectations and requirements of each organisation but where there is a will there is a way. A continuum of services - 'all managed by different parts of the system' We - the senior social services manager for older people and myself, the clinical coordinator for elderly care physiotherapists - set about agreeing across the whole system, things like access criteria, service standards, describing what the team should be in terms of staffing. This was for community settings across the county. It was a whole systems strategic group - health authority and multi-layered group across social services and the specialist orthopaedic trust and someone from Age Concern. The integrated service went live a few years ago. That was a continuum of services - ours was Community Rehabilitation Services [CRS] - multi-professional - in their own homes. When people had been stabilised our goal was to re-enable

people, to in-reach into that family to help people regain their independence. In early 2000 social services set up a re-enablement home service called Rapid Response Re-enablement - RRR. 'Re-enablement' is our county word. Social services are more comfortable with 're-enablement' - it's broader. 'Rehabilitation' is more specific. It's like 'therapeutic'; it can mean a monopoly of the [therapist], or you can say day care is 'therapeutic' in keeping people at home. 'Re-enablement' is not the easiest word to use, I would be surprised if it got resounding support from patients and service users. They like to have 'services' and 'treatment'.

Then there was the Intensive Community Support Services - 6 weeks of equipment and home care support including nursing and an OT to prevent avoidable hospital admission. We were all managed by different parts of the system, with different funding streams. Patients did move through that range of services. Each of the strands would keep their own documentation for patient assessment, even down to the basic information. There was complexity about coding - all working to different systems, set up in isolation, with different pockets of money.



Intermediate Care: what about more frail clients?

Then came the requirement from the government to develop Intermediate Care services, responding to the NSF for older people and the NHS Plan. Locally it caused some difficulty. The access criteria for Community Rehabilitation Services had been debated and did include those patients with multiple and profound needs who were going to need a slower stream services [more weeks] starting from a frailer situation, not necessarily ready for more independent living.. That has caused us a great deal of discussion. If we are now being re-badged as Intermediate Care without giving consideration to what it meant, our current patient profile included those who were more frail. At the moment we are counting them carefully. The problem is there are quite specific targets for Intermediate Care. To be successful in achieving those targets, those PCTs who have been early winners are those who have been very focussed, and stayed within that definition of a time limited services, plus or minus 6 weeks. Our throughput isn't as fast as it would be if we were taking straightforward bread and butter Intermediate Care cases. If you focus on them, you get lots of people moving through out of the acute trusts, through the Intermediate Care and then independent, back to walking to the shops and to church. But you have to recognise that these frailer people who have had a fall and a fracture and possibly also blood pressure problems and perhaps some early cognitive impairment, where are they going to get a service if we are going to concentrate on the relatively uncomplicated? It's a shared value that you need to pay attention to more complex cases.

The voluntary sector

There is capacity and a will to contribute in the voluntary sector. There is an NHS day

hospital situated in a residential care home. It runs 3 days a week, and can also work on a domiciliary basis. In 1999, Social Services, Age Concern and the trust got together to plan a high dependency day care service - a social day care service for those patients with multiple and high level needs. That is run by Age Concern in the day hospital on the other 2 days a week. We share a lot of resources, including charitable funds. An excellent example as most of the patients are well known to the day hospital. The relationship is so good between these two services that day care will contact the NHS staff who will go and do a multi-professional assessment so that moving and handling and nutrition are documented and care-planned. A really good example of soft stuff, working across boundaries, you don't need massive organisational change you just get on and do it.

Investing in capacity

For rehabilitation to be effective, it needs to be intensive. We need to build the workforce with core rehabilitation skills, not necessarily those who do the initial professional assessment. If we are going to win, we need to invest in the capacity. For a lot of therapeutic practice and rehabilitation, you don't need to be a registered professional of any background to deliver the practice. That is a work-stream happening at a pace. There are opportunities for workforce redesign to make the best use of our registered professionals but also to develop not just the assistant role but also the next couple of tiers - NVQ 3 and 4 clear goals, well trained support staff who have the capacity to work one to one. We want many more staff in band 3 and 4 in Agenda for Change, and to build a workforce that looks like a pyramid. We are beginning to see a sprinkling across the bandings. The pathway through the system is not straightforward and not efficient. Very often people get stuck in a setting because there is not capacity in the next. Sometimes people get stuck in the acute unit, or in the community hospital, and there might not be the capacity or the funding so they have to sit waiting for that move.



Mental health

The other challenge is to weave that mental health strand through the core. With our work with older people, we are finding increasingly many more clients with cognitive impairment. The Mental Health care trust are recruiting to a specialist Intermediate Care team for acute mental health needs, to prevent hospital admissions. We could do with some CPN [Community Psychiatric Nurse] support to help us learn the skills. We need to look at our skill mix. If we had a vacancy in a OT post in an Intermediate Care team, you might try and recruit an OT with a mental health background. The MH trust are good partners, they have been supportive in offering training, link nurses. Diversity Our interface with the

travelling community is very limited. What we need is education with our own teams, how you use your really skilled care workers, support them with really good training programmes, especially on soft stuff like communication. It's about us not being as clear as we should be about articulating what is possible, clarifying with people what their expectations are. There is still a culture of the NHS will make me better. With rehabilitation, the service will help you understand what you need to do and give you the equipment and review it with you. It's not a class thing, not an education thing. I can think of very ordinary people with little in terms of material possessions, well supported by family, with excellent outcomes. Exactly the same with very well-off people, who have worked their socks off. But I could give you the same number of examples of highly intellectual very well-off people who simply expect that someone else will make them better. It's in each individual's makeup. It's also the skill of the person describing to you, 'This is what we need to do to make things better'. In this part of the country there are not many people from ethnic minorities. We don't have much experience of people who don't speak English. We have good access to language line, and translation support, it's not something we come across often.

'Even where there is a genuine will'

The different statutory requirements can get in the way even where there is a genuine will. For example, Social Services had to find the money to support an electronic assessment process. It would have helped if we had gone for the same interim solution. But our financial position is such that we cannot. We have IT systems that don't talk to one another: that is deeply unhelpful. The requirements of Social Services are nothing like what the NHS has to report in terms of activity, data, coding, and outcome. If only there was a platform where these systems could go and talk to each other. The culture has softened a lot in my 10 years' experience. The NHS has a tendency to be quite empowered, quite autonomous, probably why we end up in such financial problems. The hierarchy in Social Services is much more evident. Through that they manage their finances in a much more controlled way. I would say that there is less freedom to act. The constant reorganisation impacts on people's capacity to take on new work. It takes a lot of management time and your energy for developing things is diverted. And you are thinking, what about your own job?

I have been singing the hymn of behaviour rather than structural change. But because of a need to control the finances, we are looking to integrate it through structures. There is the need to use resources a bit more flexibly. For example, a patient needing a hoist to get from a bed to a chair; there would be a lack of clarity if it should be supplied by social services or the NHS. Generally we issue the equipment and argue about the money afterwards. The issues are, is it a short or long term need for this patient, or transferring from an acute setting with equipment needs that should have been within that acute package of care. What we need is one great pool of money.

The success of local schemes is dependent on having a few key individuals with a bit of creativity and energy. The challenge is to sustain improvements when those key people move on. What I've seen is some excellence in practice, but when some key people moved and were no longer visible, people reverted to more siloed ways of working.

We need to invest in leadership and practice development; you can't do it for 6 months and then withdraw it and imagine it will carry on. You need it there all the time, supporting and developing people.

Katie's story: Intermediate Care manager, jointly employed Setting up Intermediate Care

Issues in the story

In [our county] we have the County Council and 5 PCTs. They decided to amalgamate the services that are called Intermediate Care that provide services to clients and service users in the community. But they needed managers to sort this out. They advertised and appointed three managers of Intermediate Care in the county who are jointly employed by both Health and Social and Health care. Our salaries are paid half by each so we are definitely partnership working as far as that's concerned. Our remit was to integrate the services that make up what is deemed as Intermediate Care. [Link to introduction](#)



Boundaries

We work to the county boundary for social services employees, but the PCT boundaries for health employed staff. They are looking for a single management structure to bring all those people into line. The ideal to be a client /patient centred service rather than services working in isolation: to assess the client and to offer in the community the best of what practitioners can provide, addressing each client individually. Whereas originally everything was done in isolation - someone would have a nursing-type service, then they might get another type of service. We have been looking at the patient may need nursing care in the morning but re-enablement in the afternoon with physiotherapy input. So we are breaking down those barriers.

Criteria

They all had different criteria, the 3 criteria being - re-enablement which was more the therapy services- that were more social services input; and the health input criteria being to facilitate hospital discharges and preventing admissions. We have amalgamated those 3 criteria. They all work under those criteria into Intermediate Care care.

Legalities

Obviously working in the statutory bodies they are legalities involved and we have had to go through staff consultation before we can go through a formalised integration. That is a 3 month process. It is very very frustrating. We've met on a county level with staff; we've met individually in the locality. I have an equivalent in the north of the county, in the city and myself, we are the 3 managers of Intermediate Care working very closely together. We have what called a locality leads group which is supported by the 3 managers of Intermediate Care and the PCT leads and the Social and Health care leads. We work very closely together, looking at the concerns about protocols and procedures and what we can

do and what we can't do... Having to bring in HR from the 5 PCTs and Social and Health care and the unions. So we are trying to get a whole group of people to work together for common direction to make it happen, breaking down the barriers and finding a way around the restrictions.

Right now we are actually blocked by legality - something called a Section 31 agreement, which means that a member of staff from social services can manage a member of staff from health and vice versa. So that is what we need- the legal side. The frustration was that this was flagged up to the statutory bodies about 6 months ago and they have only just said 'Oh we need this', so everything has come to a halt,. They see the point of the client-centred services but we are stopped by restraints. That's the bit that is very very frustrating at the moment.

Common processes

There's a lot of work going on behind the scenes to make it possible. There are 12 different ways of collecting data across the services. We are working with the Department of Health and Social Services to look for one common data set. There are as many types of paper work as there are services. We are looking for a single set of processes. All this is linked to the Single Assessment Process which has been rolled out nationwide. We are looking to bring on board the GPs as well.

Access: one 'front door'

What we have set up for access into the Intermediate Care is called an ARC - access to rehabilitation and care within localities. That is manned by a qualified clinician so all referrals into the service come through one front door. We have self-referrals from the public; we have GPs we have district nurses. Anyone can refer into the service. That is assessed at source, a referral is taken over the phone and is directed to the most appropriate service.

Budget

Unfortunately we are still working in isolation. Once we get integrated we will work in locality within the framework of the resources that are in that service. That's what we are heading for. We are very much restricted by budgetary restraints. ..they are £34 million overspend for health budget. and £2m overspend from social Services budget within ..shire. WE are trying to do this at nil cost. So there's a challenge.

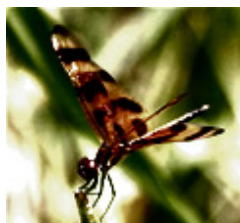
Users

What is a major concern is the fact that we have not actually consulted with our client group. We are looking to a seamless service and with the viewpoint that the clients should not see any differences . Provided the service is done at their home when it is needed, I don't think clients really realise whose uniform they are wearing- provided the service is

there when it is needed.

Not how to do it, just do it

There's a lot of change ahead. We have to deal with the fact that we are not TUPEing ; we are not setting up a trust. The staff will be employed by their original employing bodies so they have to be managed as such. The logistics of doing that, having to put in locality managers to manage a group of staff who have the knowledge across both health and social care. It's a huge learning curve. Our remit was to integrate. We are joint working. Not how to do it, just do it. It's given us a lot of licence. Fortunately the 3 managers of Intermediate Care, myself and my colleagues, work very closely together. We are looking for common protocols, common procedures, common training.



Generic posts

The ultimate outcome for non-qualified staff will be a generic care worker across both health and social and Health care who will be trained in both care and re-enablement looking for the NVQ3. We will be employing therapists to work across both communities and community hospitals. Re looking at job descriptions a whole different way of working in the community. Moving from a bed based service to a community based service. In shre in the south of the county alone there are 191 community beds and 20 Intermediate Care beds. That's a lot of beds. The community hospitals do have a lot o trouble staffing those beds. There are going to be major changes. There will be bed losses in the community. Therefore we have to build the community teams up.

We will get there

It's purely a financial restraint that we are working to all the time. It's the fact that the staff see the way forward; those above see the way forward. We will get there. We've got our deadlines. We are not giving up, we're just ploughing ahead and working very very closely across the county . There has been a lot of support from executive levels both health and social services, They have an integration Board so we are getting support from a high level - from Director level and ground level. Everybody wants it it's just getting there. .

Issues in the story

Views of users

The users we hear from are very satisfied, particularly Mr and Mrs. A who contrasted it with the absence of support when Mr. A first came out of hospital. They are also very grateful, though Mrs S noted her own determination to recover. Mr. A said 'they decided to take me on': he clearly did not feel his choice was over-riding the professionals.



Consultation and involvement

Notably, users were not consulted at any stage. There were different views on how far staff were consulted. [Edward : only managers were consulted, and that was about the management structure. Brenda :formal consultation with unions, and was very aware of the amount of time she needed to set aside for this.]

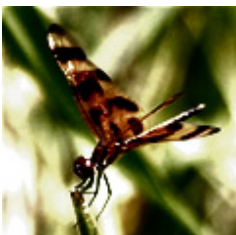
Layers of integration

There are a number of different ways in which the term 'integration' is used in this story.

1. Through behaviour or through re-structuring [Amanda page 1]. Structural integration can be carried out through joint management with shared leads, as in this case; or through single line management which could either in the PCT or in social services. [Edward and Amanda]; or through a Care Trust to work with older people as a separate organisation.
2. Through co -location for example a residential care home which houses a NHS day hospital care home and social day centre run by Age concern. [Amanda]
3. Through a new generic role eg Care Provider, combining the roles of therapy assistant, care assistant, and some elements of Home Care [Valerie]
4. Through integrated training: Care Providers need integrated training and changed expectations so that they can work with all types of clients, from those who will return to active life to those who are at in the last phase of their lives.[Amanda]
5. Through good access to all other professionals [Valerie care provider p 3]
6. Through combined referral procedures: in this story however, the integrated IC desk is not open at weekends.

Professionals and professionalism

There are positive approaches to broadening concepts of professionalism: 'multi-professional' managers' [Imogen] . However, senior professionals are 'playing silly buggers' [Edward p2] There is a fear of joint management, [Brenda p 2]; and anxiety about clinical supervision which 'failed to materialise'. Edward p 2 Valerie the Care Provider is a generic staff member [Valerie] .Registered professionals do not need to work with all patients [Amanda] Valerie mused on whether she was a clinician herself: [link to 'I wouldn't call myself a clinician. I am in one sense. In another I'm just a provider of care.']



History

There are different approaches to history: Brenda and Imogen say they have been doing integrated care for years. [Amanda : ten years ago in inter-disciplinary care, with a hospital social worker involved and joint records, though it is not clear if those too cross all groups]. Katie

focuses clearly on the present task. We wondered how selectively people remember the past. What is striking is the length of time and the difficulty it has taken to reach this level of integration and the problems that still remain. [Brenda 'This is where we wanted to get to a few years ago'] Autonomy over budget Health as 'more free and easy'; Social Services' can't sneeze without filling in a form'. [Imogen, physiotherapy background];

Outcomes and drivers

On the continuum from those clients who can do well with re enablement, to care and support for those at the end of their life.

Real changes in people Valerie worked with. [Valerie]

Meeting performance indicators for star ratings and increased budget [Edward]

Pressure from the government IC targets to achieve hospital discharges over-riding the use of the appropriate services [Amanda].

Performance review

Opposing views on whether health or social services have more performance indicators.

[Imogen and Brenda (both therapists)].

Cultural difference in the type of indicators: health deals with outcomes and outputs and finished episodes, S&CS have process measures, reflecting the ongoing relationship that social care may have with clients.

Forms/ data management

All except the clients saw different records as problematic, with 12 different systems

[Katie].i Initial records are different for each staff group and in hard copy; work review

form faxed [Valerie]. Data bases are quite separate for health and social care [Edward] Pay

Differential health/social care mentioned by all the managers; discrepancies even for managers doing the same job. Pay reflects how far people feel valued [Imogen]

Language

The term 're-enablement' seen as invented in this county; preferable to 'rehabilitation' seen as clinical [Amanda and Brenda] 'Patients' /'clients' 'winning'; 'bread and butter cases' 'PC world'

Leadership

A gap in strategic leadership, and operational managers were left to get on with it [Edward].

'Not how to do it, just do it' 'determined' to carry through the integration, in spite of the

difficulties she was very aware of. [Katie] Positives experienced by those in this story

What was going well in this story includes the following:

The users' good experience of the service New generic worker role provides a career

development path for unqualified staff Integrated care has a value in itself. Some

experienced an excellent culture of working together; close cross agency management

working as well as effective Integration Board [Katie; Imogen: people worked v v well in partnership on the ground. Brenda: PCT managers are keen to work together] A few key individuals with creativity but the question remains about how to sustain this when those individuals leave There has been more effective use of beds through the joint IC access desk Faced with insurmountable national pay differentials, Brenda did the best she could, and involved Human Resources in effective way.

Barriers

The following continued to be barriers to effective integrated care.

Pay Lack of co-location Delay in getting Section 31 'very very frustrating' Katie

Professionalism Criteria for access to IC: also free v means tested

Different funding streams Imogen

Different Performance Indicators; different paper and IT systems

Cuts without consultation with partners Brenda

Lack of capacity to move clients on; not enough time for training [Edward] Lack of clinical accountability [Edward]

Boundaries PCT and Social Services Senior managers moving on, not knowing history, some not knowing about IC Culture - language PIs etc control and empowerment etc.

[Powerpoint - dimensions and tensions](#)

Major issues

Constructing Integrated Care has been going on for 10 years and is still difficult
Elderly people live longer, with more complex conditions; at home when previously would have been in hospital

Users still very grateful A lot of goodwill people on the ground want to do it; not sufficient support, resources, common data systems

Managers responding partly to Performance Indicators

Behaviour v structure: the barriers are structural and professions

Lack of resources. Why no section 31?

Lack of user involvement. Voluntary organisation there as service provider, not as part of strategy. no pressure group support.

Hardly any mention of privatisation/ externalisation

