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Research Article

Implementation of Step-Down Intermediate Care (IC) in Buckinghamshire, UK: A Qualitative Evaluation Study of Healthcare Professionals' Experiences and Perspectives

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Step-down intermediate care aims to offer short-term care for people who are medically optimised for discharge but needing a period for further assessment and/or rehabilitation. The aim of this study, which was nested in a larger evaluation project, was to explore the experiences and perspectives of healthcare professionals to understand the implementation of a step-down IC service in Buckinghamshire, UK. The evidence is used to inform the service providers of what elements worked well and what areas require improvement. A qualitative study using semistructured interviews was conducted in May 2022. Ten healthcare professionals participated. Interviews were transcribed verbatim and reflexive thematic analysis was used to analyse the data. The following five core themes were developed: (1) the developmental period of step-down IC, (2) providing care together, (3) perceived functions of the integrated hub, (4) communication, and (5) resources. Findings from the interviews highlighted the excellent working relationships among healthcare professionals from different disciplines, which contributed to their job satisfaction and the efficiency of the service. In addition, healthcare professionals stressed the importance of the integrated hub, as it facilitated the communication between the teams and speeded up the decision-making. Several organisational challenges, such as communication issues, healthcare professionals' capacity, and the need for further funding were also voiced. Involving staff in the evaluation of a step-down intermediate care service has provided useful information on the service's implementation process and will inform the development of a long-term strategy for intermediate care.

1. Background

Intermediate care (IC) is defined as a range of integrated services, with the aim to support timely discharge from the hospital, prevent unnecessary hospital admission, promote faster recovery, and minimise functional dependence [1, 2]. The aim of step-down IC is to offer short-term care for people who are medically optimised for discharge but needing a period for further assessment and/or rehabilitation [3]. The goal of an IC setting is to provide holistic care, taking into account psychological, social, and physical factors that influence patients' health [4]. This in line will address the issue of fragmentation in healthcare services, which is linked with decreased patient satisfaction, lower quality of care, higher healthcare costs, and poor clinical outcomes [5, 6].

In the UK, delayed transfers are an extensive problem for the National Health Service (NHS) as it creates unnecessarily long stays in hospital for patients who are medically fit to be discharged and increases the risk of healthcare-associated infection (HAI) [7, 8]. Delayed transfers are also associated with high bed occupancy rates causing elective backlogs and

long waiting lists for surgeries and treatments [9]. To address the issue of delayed transfers and to support the flow of patients' care from hospital to their homes or an appropriate community setting, where their individual needs can be addressed, the patient discharge framework has been developed. The framework aimed to reduce the length of stay for people in hospitals and is divided into three lots; discharge to assess services, third party brokerage, and medical care at home [9].

The Discharge to Assess (D2A) care model describes three intermediate care pathways which provide "step-down" care following an acute hospital stay. Pathway 1 provides additional support at home/usual residence; pathway 2 provides short-term rehabilitation in a temporary bedded setting; and pathway 3 provides long-term care home placement (nursing or residential) [10]. There is no "one" model of delivering D2A. However, the D2A policy outlines evidence-based principles that can be followed by IC services as design principles that underpin a D2A model [11]. The principles for the D2A model are the establishment of essential criteria before the admission to IC setting, patient-centred care, easy access to service, effective assessment, easy information flow, networks of care, access to resources, and continuous evaluation and feedback. The implementation of a D2A model provides alternative pathways for people who cannot be discharged unsupported to their own homes.

Against this background, Buckinghamshire Healthcare NHS Trust, Buckinghamshire Council, and Buckinghamshire Clinical Commissioning Group have collaborated to develop a step-down IC service for patients who have been assessed as medically fit for discharge but still require either therapy input, social care input, or final arrangement for care packages. The service was initiated as a bedded care facility on the 31st of January 2022 and concluded on the 27th of May 2022. During this time, it provided accommodation and personal care for up to 22 patients at one time. The bedded area was situated in a nearby hotel that was equipped to accept patients. The step-down IC service aimed to provide bed-based care for Buckinghamshire patients at the end of their episode of acute care and the encouragement of independence, whilst patients are waiting for their home package of care or onward placement. Figure 1 illustrates the D2A model and where the step-down IC service fits into this model.

To date, several studies have explored the area of IC. Previous qualitative studies focused on patients' experiences with IC services have suggested that patients feel that they have benefitted from intermediate care, as it improves their quality of life by supporting them to better take care of themselves, move with confidence, and by enabling them greater social participation [12, 13]. A recently published review focused on the effectiveness of IC found that bed-based IC is linked with reduced readmission rates and length of hospital stay [14]. Furthermore, recent studies exploring experiences and perceptions of healthcare professionals from an IC setting focused on understanding patient's participation in IC [4, 15] and the attitudes of healthcare professionals towards the physical restraints on patients in IC [16].

Despite the efforts to improve the quality of IC, research shows that there is little evidence of how to address practical challenges that may arise [14, 17]. To provide a practical guidance on "what is needed" to provide high quality of care in an IC setting, it is important to gain a deeper understanding of "what works" in an IC setting in terms of organisational processes and resources. Understanding healthcare professionals' experiences and perspectives can be used to improve care, identify problematic areas, and develop strategies to address them. We believe this is the first research study that aims to fill this gap in the literature and explore the experiences and perceptions of healthcare professionals regarding the implementation of an IC setting.

The aim of this study, which was nested in a larger evaluation project, was to explore the experiences and perspectives of healthcare professionals to understand the implementation of a step-down IC service in Buckinghamshire, UK. The evidence is used to inform the service providers of what elements worked well and what requires improvement.

2. Methods

2.1. Study Design. This study aimed to explore the experiences and perspectives of healthcare professionals to understand the implementation of a step-down IC service in Buckinghamshire, UK. Phenomenology is the study of subjective experience [18]. Therefore, inspired by the phenomenological approach, the experiential and lived aspects of health professionals' experiences were explored. A qualitative interview design was employed to explore healthcare professionals' experiences and perspectives in relation to the implementation of a step-down IC service in Buckinghamshire, UK. The consolidated criteria for reporting qualitative research [19] were followed in the reporting of this study (Supplementary file 1).

2.2. Participants and Setting. The present study was conducted in a step-down IC service in Buckinghamshire, UK. A purposeful sampling method was used to obtain variation in participants' professions. The inclusion criteria are healthcare professionals, who were working in the service and being involved in transitional care of patients from acute care to home. Ten healthcare professionals participated in the study. The sample included occupational therapists, dieticians, general practitioners, consultants, nurses, assistant nurses, pharmaceutical staff, healthcare assistants, and social care workers.

2.3. Data Collection. The matron of the service was contacted by the lead researcher, FL, to provide a list of potential participants. The matron circulated the participant information sheets, obtained initial agreement from the participants, and forwarded contact details to the researcher (FL), who invited the healthcare

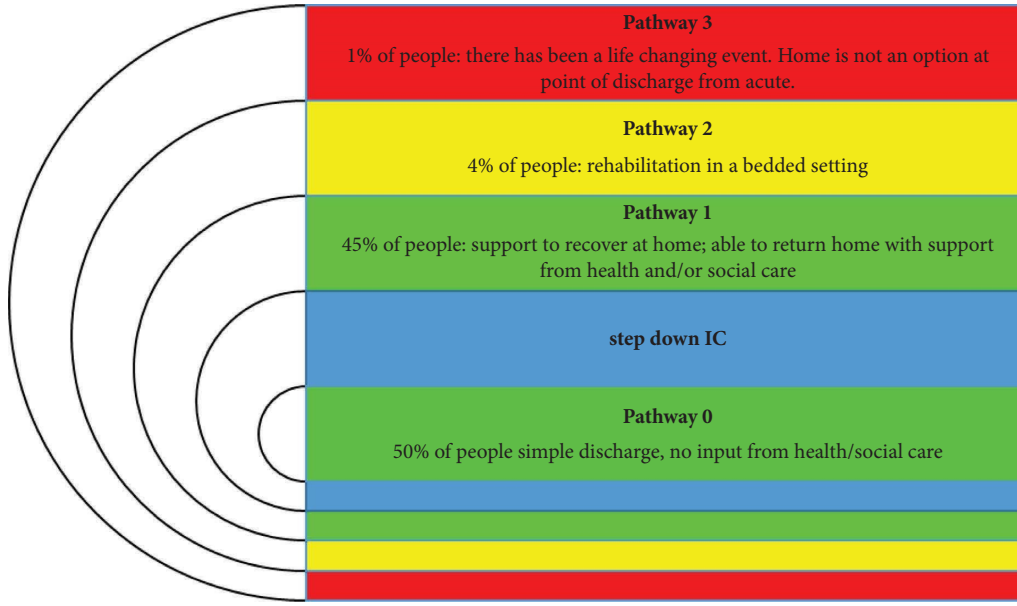

Figure 1: Discharge to assess model.

professionals to take part. The interviewees provided written informed consent.

Online semistructured individual interviews were conducted through the Microsoft Teams platform in May 2022 and lasted between 16 and 24 minutes. Data saturation was monitored continuously throughout the recruitment process, as the coding of the transcribed interviews began before the full dataset was available. Data collection was stopped when saturation was reached by the 7th interview. Participants were informed that interviews would be audio recorded using the researcher's personal audio recorder. The participants were assured that any identifiable information about them would not be disclosed.

The interview schedule was informed by the literature and was discussed with the coauthors, who have extensive research, clinical, and administrative experience in the NHS. Topics included the experience of team working, the effectiveness of the integrated hub, communication among healthcare professionals, training, and availability of resources. The interview schedule was not piloted but after the first two interviews; it was discussed by the research team to determine if any changes needed to be made before proceeding. The interview schedule for this study is provided in Supplementary file 2.

2.4. Analysis. All audio-recorded interviews were transcribed verbatim by FL. All transcripts were imported into the computer-assisted qualitative data analysis software NVivo [20] to assist in the analysis of the data. The analysis of the interviews was conducted by a single postdoctoral researcher, with prior training in carrying out qualitative research. Twenty percent of the transcripts were double-coded independently by YP, and any discrepancies were discussed between the two coders. The final definitions of the codes were assigned when the two coders agreed.

Reflexive thematic analysis (TA) was used to analyse the transcripts. The reason for using reflexive thematic analysis is that it is a flexible interpretative method and it is concerned with exploring the truth of participants' contextually situated experiences [21], which is in line with the aim of the study. In addition, reflexive TA is a robust method of qualitative analysis appropriate to inform policy development [22, 23]. Trustworthiness is the recognised measure of rigour in qualitative research [24, 25]. Reflexivity is one of the quality criteria in qualitative research that ensures trustworthiness [24, 25]. Trustworthiness was achieved through the use of the researcher's reflective notes during the research process, in the coding process. A coding tree was produced to assist with visualisation of the findings (see Figure 2).

To perform the data analysis in a structured method, the six-phase process for data engagement, coding, and theme development proposed by Braun and Clarke was followed: (1) data familiarisation and writing familiarisation notes; (2) systematic data coding; (3) generating initial themes from coded and collated data; (4) developing and reviewing themes; (5) refining, defining, and naming themes; and (6) producing the report [22]. An inductive approach to data coding and analysis was employed, where the code and the themes were derived from the content of the data themselves.

2.5. Ethical Considerations. All measures to safeguard the participants' safety, privacy, and anonymity were taken. The study was approved by the Institute for Health Research Ethics Committee (IHREC) of the University of Bedfordshire, UK (application no: IHREC940; date of approval: 05 May 2022). All participants signed a written form of consent after having received oral and written information about the study. To protect anonymity any information, that may reflect the identity of the participants, is not included.

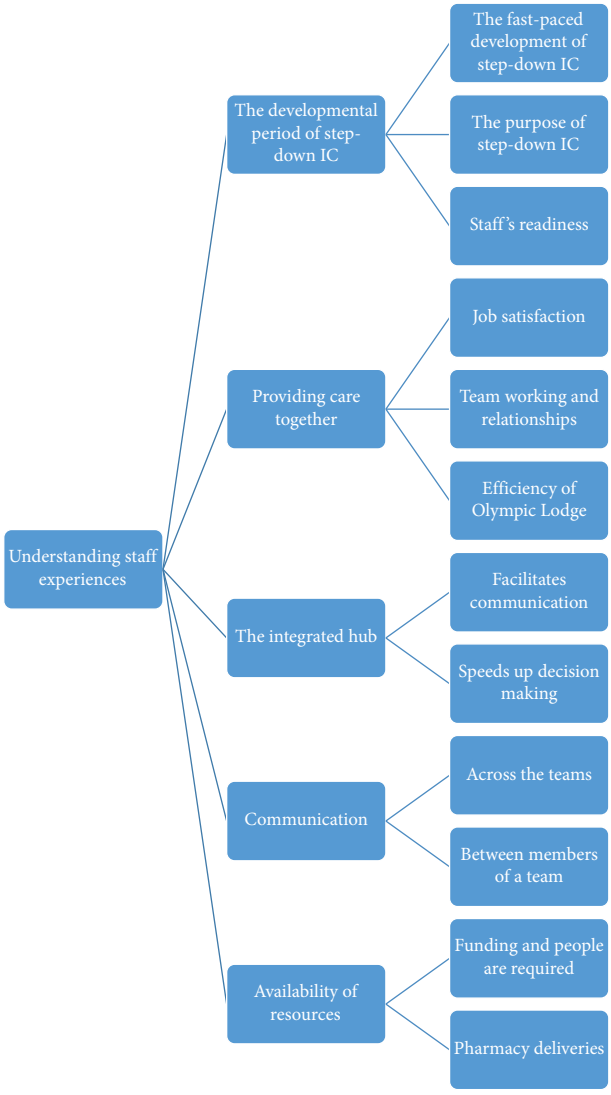

FIGURE 2: The coding tree of the key themes identified from the data investigating staff's experiences.

Each participant is ascribed as a "participant" and a number, e.g., participant 1.

3. Results

This section presents the findings of the interviews, which addressed the experiences of members of staff of the step-down IC. The thematic analysis led to the identification of the following five main themes: (1) the developmental period of step-down IC, (2) providing care together, (3) the integrated hub, (4) communication, and (5) resources. These core themes were structured into subthemes to further describe the staff experience.

3.1. Theme 1: The Developmental Period of Step-Down IC

3.1.1. The Fast-Paced Development of Step-Down IC. Participants commented that it was challenging to develop a new service on short notice and with limited resources and stressed the fast-paced development of the step-down IC. Despite the challenges, they described the development of a step-down IC as a positive experience because now they know that they are able to set up a similar service overcoming organisational challenges.

> *"We are now very used to getting new services turned out from scratch in like lightning speed. Because we were told we have to open this new service like by tomorrow. It's very, very short notice. [. . .] Overall, I think the experience is quite positive because we are able at very short notice and with very scant resources to produce this care." (Participant 1)*

3.1.2. The Purpose of Step-Down IC. Step-down IC was described as a "holding place" for people who are medically fit to be discharged from the hospital but their package of care has not been arranged yet. Also, the service designed to provide efficient rehabilitation to avoid unnecessary future hospital admissions.

> *"People who are completely medically fit and if we had the social care required for them, they would have been sent home directly or to a care home. So this was a holding place equivalent to a care home where people whilst they were waiting for whatever had to happen, were being provided with further efficient therapy, some rehabilitation, or at least to maintain their mobility, but also, the idea was to provide minimal medical input because you don't want to keep medicalizing these patients." (Participant 1)*

3.1.3. Staff's Readiness. One participant stated that they had a one-day induction before the first few patients were admitted to the service.

> *"Yes, we did a one-day induction. A full-on induction with important things, like the OTs training us on equipment, with the pharmacists coming on to tell us how things were going to work. So it was quite a full induction, a day or two before the opening." (Participant 2)*

In contrast, the majority of the participants stated that they did not have an induction or any training before the service commenced.

> *"No, really. No, we had some sort of a meeting with the team and they kind of talked through what the objectives of the lodge were. But not specific induction for myself, no." (Participant 3)*

> *"No. I just did my job in a different place." (Participant 5)*

3.2. Theme 2: Providing Care Together

3.2.1. Job Satisfaction. Job satisfaction was expressed by all the participants. They voiced that they have been motivated by the benefit to the patients and by the continuous learning

that the service offered to them. Also, the participants stressed that they enjoyed working with different teams.

"So, I think what drives us, drives me is the benefit of the patient. I think it's always good to get patients out of hospital." (Participant 1)

"I'm not gonna lie by any stretch. It was hard work. But it was lots of learning and lots of different situations to deal with. It's always fascinating and I really enjoyed it. And I enjoyed working with all the different parts of the team." (Participant 4)

3.2.2. Team Working and Relationships. Participants highlighted how the teams are working together and the supportive relationships that they have developed between the members of staff. At the beginning, the participants stated that it was difficult for them to work away from their team and with people that they did not know although people started to know each other and stronger working relationships were developed.

"I think teams are really friendly, really helpful, and always receptive to what we recommend when we come and see people here." (Participant 3)

"So first of all, it was a little bit difficult getting used to being away from my team. And we were all a bit shy, sort of introducing ourselves, to begin with but then we all settled in and we got familiar with faces, and it became a lot genial, and I got used to who was who, what role they played." (Participant 5)

Respecting others' opinions and complimenting their effort was a strong subject that was revealed in the participants' narratives. Participants clearly stated that they respect the nursing opinion, as it is another side of the view, which facilitates problem solving. Also, healthcare assistants were praised for their performance, by other health professionals.

"For me, the nursing opinion is very important. Because they have their side of the view. I have my side, so I prefer either the nurse have any advice or any concerns to share with me so we can discuss this problem and find the proper to fix it." (Participant 10)

"The healthcare assistants were absolutely brilliant. They really made an effort to get to know patients. [. . .] I couldn't rate the healthcare assistants high enough." (Participant 4)

3.2.3. Efficiency of Step-Down IC. Participants commented on the efficiency of the service. They stated that there was a turnover of patients, which showed that people did not stay for a long time at step-down IC and were discharged back to the community with the appropriate package of care.

"There's quite a good turnover of patients. So we can see that people are moving on fairly quickly." (Participant 3)

Also, the participants stated that they were encouraging patients to be as independent as possible and staff to work on promoting independence to patients. Although the participants stressed that independence is not something that comes easily to nursing. One factor that impeded the promotion of independence was that patients used to be dependent prior to their admission to the hospital and they were expecting that someone would take care of them after their discharge from the step-down IC.

"We try to encourage our patients to be as independent as possible." (Participant 2)

"We're doing our best, it very depends on the patients, because some of them they used to be. . . how to explain . . . they used to be dependent. Before they go to the hospital. They went to the hospital, after the hospital, they have somebody who look after them. So they used not to be independent." (Participant 10)

3.3. Theme 3: Perceived Functions of the Integrated Hub

3.3.1. Facilitates Communication. Participants presented their views on how the integrated hub facilitated the communication between the health professionals. The integrated hub offered a space where health professionals were working together and their communication was instant. They were able to discuss any concerns about a patient's package of care easier and quicker.

"I think it was really helpful to have everybody in that space because if somebody had a question for someone's package of care. . ., I can just go and have a conversation with the occupational therapists, see what their assessment was, talk it through and work out whether or not that is what somebody really needs and vice versa. It was a bit easier to have those conversations because sometimes it can be quite difficult." (Participant 4)

"It was good that we had a huddle every morning. So basically big whiteboard with everyone's names and actions. So that was really good to know who was doing what, at any particular time. And the board was there, so we all had something to look at, which made it so much easier than going into different spreadsheets on your computer. So that was good, especially just knowing who was doing the action, and what part of the process the service user was." (Participant 5)

3.3.2. Speeds up Decision Making. Participants expressed that the integrated hub made the assessments and the information flow between the teams quicker. Because of the close proximity of people, the information transfer was much quicker than when people used to rely on communication through phone calls or emails. Also, the integrated hub allowed a direct flow of information from one team to the other, which allowed a quicker decision-making process.

"I think the main advantage was being able to get information speedily. So no need for telephone calls or emails.

A quick word. I found that my assessments were quicker than usual. Obviously, because everyone was under one roof. Because of the close proximity of people. You can always pop up and see someone and ask a question and come back. So yeah, quicker, definitely quicker." (Participant 5)

3.4. Theme 4: Communication

3.4.1. Across the Teams. Participants highlighted that they had good communication across the teams. Even when someone was not available immediately, they had ways of communication, such as a message book although they rarely had to use this book as they were working under one roof, which made communication easy.

"I think we have good communication. Even if I'm busy with something we have a book. If it's not something urgent, they write me my task, and their concerns in this book, and after that, I check it and I will fix it. Usually, we communicate without this book, the book is almost empty. [. . .] I'm assuming it's easier to communicate if you are face to face with someone." (Participant 10)

Although some issues of communication were revealed, the communication between the step-down IC and the hospital relied on a mobile phone. Participants expressed that the communication through the mobile phone was a challenge, as the network was not good. Participants also recommended that the communication channels should be looked at more carefully if the step-down IC is going to reopen.

"Our only source of communication is a mobile phone, which is not good. The network is not so good. So that has been a challenge. [. . .] So I think if the step-down IC *is going to open again, they really need to look at put this thing in place, before we open, because we are far from the hospital and other than sending someone over. There is no other way of getting things from the hospital than talking to them." (Participant 2)*

3.4.2. Between Members of a Team. The communication between members of a team has been reported to be effective. Participants stated that they have been very well organised with how to hand over information and document progress.

"The communication with other members of the team has been good because we do handovers twice a day and also have had those in between and that is helped in the update. So that helps with communication between ourselves. So that's not a problem at all." (Participant 2)

3.5. Theme 5: Availability of Resources

3.5.1. Funding and People Are Required. Participants highlighted the need for more people and, therefore, further funding. Participants have demonstrated that they can implement the service but they stretched their limits. They stated that they would be able to improve the patients' health outcomes if they had more staff available.

"Equipment-wise, we managed the equipment that we could get. I think realistically the main resource was humans. That was lacking. [. . .] It was hard. And that's partly because there wasn't enough of us. [. . .] I think that was the real gem that we would be able to reduce people's needs when they go home. We just didn't have the bodies on the ground. We really couldn't fulfill that potential. I think that, is a huge area for improvement." (Participant 4)

3.5.2. Pharmacy Deliveries. Participants also raised concerns about the pharmacy deliveries. They stressed that the process of handling the drug supplies towards the step-down IC was not rigorous. They suggested that the process should be looked into if the service is going to reopen.

"The main problem that we've had is sometimes with pharmacy, because we do have people that go home with a set of boxes, and sometimes the process of it I think it will need to be looked into, when we open next time, because the process is not very robust. And sometimes we fall short. So that is the main thing that I'd like to highlight in terms of resources." (Participant 2)

4. Discussion

The aim of this study was to explore the healthcare professional experiences and perspectives to understand the implementation of the step-down IC in Buckinghamshire, UK. The overall findings suggest that involving healthcare professionals in the evaluation provided useful information on how the step-down IC operated and informed the development of a long-term strategy for intermediate care. Healthcare professionals provided useful information about the developmental period of the service. In all cases, members of staff reported that they had built excellent working relationships with colleagues from different disciplines, which contributed to their job satisfaction and the efficiency of the service. In addition, members of staff highlighted the importance of the integrated hub, as it facilitated the communication between the teams and speeded up the decision-making. The need for staff capacity and therefore further funding was voiced.

Team working between healthcare professionals has been highlighted in the interviews as an important factor that facilitates the delivery of care. In addition, the participants stressed that they respect views from different disciplines and embrace knowledge sharing. This aligns with previous studies, where the emphasis is on shared values and understanding, collaborative working, and trusting relationships, as enablers of the implementation of care initiatives, where interdisciplinary collaboration is required [26–31]. In addition, in step-down IC care knowledge sharing, effective communication, and accountability are required to support patients' rehabilitation plans [32]. This is

because each patient's rehabilitation plan is unique and requires the coordination of multiple disciplines and providers. Effective communication between the different providers and the patient is essential to ensure the patient receives the best care possible and that the plan is tailored to their individual needs. In addition, accountability ensures that the plan is followed and that the patient's progress is tracked.

The mention of a period of "good" patient turnover in the step-down IC indicates efficient rehabilitation, successful recovery, or timely discharge processes. During their stay in the step-down IC, patients confirmed that they were working to further develop their mobility, and they increased their independence [33]. Educating and empowering patients can improve outcomes and speed up recovery. Therefore, patients were better equipped to manage their health postdischarge and were less likely to be readmitted to the hospital. This holistic approach to care ensures that patients have the support they need to successfully transition back to their home environment.

Participants also commented on the efficiency of the service and highlighted that the promotion of independence to the patients can be challenging, as the patients were used to being dependent on their carers. However, a goal-oriented rehabilitation plan has not been revealed from the interviews. Prior studies have noted that patients' encouragement to goal setting and involvement in their own rehabilitation plan, rather than being dependent on a third party, enhance patients' motivation and confidence to increase their mobility and, therefore, their independence [31, 34–36]. Patient goal setting plays a pivotal role in healthcare by not only enhancing patient empowerment, engagement, and collaboration but also fostering a sense of ownership and accountability in the rehabilitation process. It empowers individuals to actively engage in their treatment decisions, resulting in enhanced self-management skills and improved health outcomes. By setting goals, healthcare providers can tailor treatment plans to address specific patient needs, ensuring interventions are customized for optimal effectiveness and improved recovery outcomes. Clear, measurable goals provide a framework for tracking progress and evaluating interventions' effectiveness. Attaining realistic goals not only motivates patients to actively pursue better health but also establishes a framework for accountability through regular reviews, ensuring alignment between patient progress and desired outcomes. Therefore, healthcare professionals should adopt a goal-setting rehabilitation approach to enhance patient engagement, ultimately resulting in improved clinical outcomes for the patients [37, 38] However, it is important to note that some patients may not be receptive to goal setting approach. They may feel overwhelmed by the process of setting realistic and achievable goals. In these cases, it is important for healthcare professionals to be supportive and understanding.

Healthcare professionals expressed that they enjoyed working with different teams and overall job satisfaction. In the literature, job satisfaction appeared substantially improved for healthcare professionals employed in intermediate care compared to those employed in usual care [39, 40]. This improvement in job satisfaction appeared to be linked with collaboratively working and knowledge sharing across healthcare professionals from different disciplines [39]. In addition, enhanced training appears to be a contributing factor to staff's job satisfaction [39]. Throughout the interviews, formal multidisciplinary training has not been revealed as practice in the service. Mixed views were expressed about the induction programme for staff working in service provision. It was noted that there was no consistent approach to induction, with some staff receiving one day induction training and others receiving none. This suggests that there is a lack of understanding of the importance of formal, multidisciplinary training in the service. Formal-enhanced training should be considered by step-down IC service providers, as it contributes to staff's job satisfaction and consequently to higher retention rates. Formal multidisciplinary training can help staff to better understand the various aspects of their roles, as well as the roles of other team members. This can help to create a more cohesive team environment in which staff can work together more effectively.

The contrasting views among the participants highlight significant differences in their experiences regarding the induction process before the commencement of the service. For instance, one participant reported a structured, comprehensive one-day induction, involving occupational therapists and pharmacists, emphasizing the importance of staff preparation. However, two participants reported a lack of formal induction or training, with no specific induction for themselves. This highlights a gap in consistency and support in the onboarding process and the need for standardized onboarding processes to ensure all staff members receive adequate training and support before assuming their roles in the new service. In addition, the participants' perspectives on communication revealed varying experiences. While effective channels like message books and face-to-face interaction facilitated a cohesive team environment, challenges arose between the step-down IC and the hospital due to reliance on a mobile phone and poor network connectivity. The importance of a strong communication infrastructure was emphasised, highlighting the need for comprehensive approaches to maximise team communication.

In 2008, Berwick et al. published the Triple Aim framework designed to optimise the performance of healthcare systems through the synchronised achievement of three goals, improving population health, enhancing patient experience, and reducing the cost of care [41]. In 2014, the Quadruple Aim, adapted from the Triple Aim, added a new fourth domain; healthcare team well-being [42]. Considering that the negative impact of COVID-19 on healthcare staff is well documented [43–45], the fourth aim of healthcare improvement is highly needed to be prioritised by healthcare systems to improve the work life of those who deliver care. The overall expressed job satisfaction by the healthcare professionals aligns with the fourth aim, improving the work-life balance of healthcare staff. Therefore, these findings show that the implementation of the step-

down IC meets an important component of the Quadruple Aim framework, the healthcare team's satisfaction with work.

There is a rapid spread of reablement services; short-term home-based interventions aimed at improving people's confidence and ability to live as independently as possible and reducing their need for long-term care after being discharged from the hospital [46]. This type of IC shares many characteristics with a step-down bed-based IC, such as both are time limited (usually up to six weeks) and include a restorative, self-care element in their services. A step-down bed-based IC is usually a "stepping stone" for people to transition from an acute inpatient setting to home, whilst it is a more cost-effective alternative to hospital care and offers specialist support from multidisciplinary teams to help people take care of their health and social care needs and return home with improved quality of life. Both types of IC promote early hospital discharge with specialist support to observe, encourage, and guide people to live more independently. In both settings, the goal is to empower individuals to manage their own health and care needs and to reduce the need for further acute or long-term hospital admissions. The major difference between the two is that the step-down bed-based IC is typically located in a hospital and has a more structured, medical approach to care, while the home-based IC is located in the person's home and focuses on providing support to help them manage daily activities. In addition, home-based ICs also provide support to family members and caregivers, which can help to improve the quality of life for the patient. Considering that the family is a very fundamental resource in patient care [47–49], a step-down IC setting should develop strategies to strengthen the family's supportive behaviours. For example, nurses could provide information to family members or caregivers to support their competency which will enhance patient safety.

The interviews provided valuable insights into the evolving landscape of intermediate care. This included the expansion of IC services and their role in helping patients transition from hospital to home. However, there was no view about the connections and communication with community services or the implementation of postdischarge care plans. This information gap could potentially hinder the effectiveness of the IC services in providing holistic care to patients. In the future, it would be beneficial to explore how these services can work collaboratively with community resources to ensure a seamless transition for patients.

Lastly, important insights into the communication across and between the teams of IC were revealed from the interviews. For example, communication issues between the step-down IC facility and the hospital were revealed, with mobile phone use being a challenge due to poor network. It appears that due to the rapid development of the service, there was a lack of established communication protocols and standardized methods for sharing information, leading to potential gaps in patient care and coordination between facilities. This highlights the need for clear communication strategies and technological solutions to ensure seamless communication in emergency situations. Participants suggested careful examination of communication channels if the step-down IC facility is going to reopen.

The integrated hub appeared to play an important role in enabling staff to communicate easier and quicker. Members of staff stressed that working in the integrated hub speeds up the decision-making and following the patients' plans. This is in good agreement with Brown et al. [50]'s study, which states that an integrated hub enhances communication among multidisciplinary teams and understanding of team members' roles and reduces the assessment time [50]. Participants confirmed that the integrated hub facilitated the discussion of any concerns that the staff may have had about a patient's care plan which contributed to easier and quicker resolutions. The present findings seem to be consistent with other research which found that efficient communication in multidisciplinary team meetings seemed to have a direct impact on the quality of patient care provided [51].

4.1. Strengths and Limitations. The study contributed to a deeper understanding of the implementation of step-down IC in Buckinghamshire, UK, and provides evidence for improvements to the model. The strong point of this study lies in the fact that the data are generated from healthcare professionals with different levels of education, and diverse disciplines. Participants provided insights into their experiences from different working areas. However, due to the limited number of participants from each group, this does not allow any comparisons between different groups of participants and conclusions about how different groups experienced the implementation of the intermediate care facility.

Another strength of this study lies in the fact that it was conducted in a real-life setting and analysed real-world data. The findings might not be generalisable to other IC settings, as the data are related to the context of the step-down IC in Buckinghamshire, but the real-world evidence which developed from this study can play an important role in healthcare decisions, such as the development of guidelines or to inform the implementation of future similar initiatives.

These findings should be interpreted with the consideration of some limitations. One of the limitations of this research study is that the analysis of data was conducted by a single researcher due to limited resources. However, twenty percent of the transcripts were double-coded independently by YP, and any discrepancies were discussed between the two coders. Also, according to Braun and Clarke [21], coding quality is not dependent on multiple coders and a single coder is typical in reflexive thematic analysis, especially if the analysis seeks interpretative depth, which was the case in this study [21]. Furthermore, trustworthiness can be established when the research is transparent about the data and analysis [19]. The qualitative research checklist (COREQ) for reporting qualitative studies was completed (Supplementary file 1).

The second limitation concerns the small number of study participants. However, the sample of ten participants is a reliable representation of the healthcare professionals, who were employed in the service. In addition, the

researcher conducted data analysis simultaneously with the interviews to ensure that data saturation had been achieved before the recruitment process ended.

Another limitation that could be considered is the fact that the present study explored the experiences and the perspectives of care professionals only. However, this study is part of a larger evaluation project, which included the exploration of patients' experiences too. Future research studies that aim to evaluate new intermediate care initiatives would be benefit by including exploration of care professionals' and patients' experiences.

The fact that the interviews were conducted remotely may consider a limitation for a number of reasons, including technical issues and disconnected calls, the absence of visual cues, or the participants' technological competence. However, synchronous (real-time) online interviewing can be a substitute to face-to-face interviews [52]. In addition, online data collection reduced the travel time and cost of participating in the study and enhanced the recruitment process.

5. Conclusion

Involving staff in the evaluation has provided useful information on how step-down IC in Buckinghamshire operated and informed the development of a long-term strategy for intermediate care. Members of staff highlighted the importance of the integrated hub, as it facilitated the communication between the teams and sped up the decision-making. In all cases, members of staff reported that they had built excellent working relationships with colleagues, which in line led to job satisfaction. The need for more staff and, therefore, further funding was voiced. The development of IC services is a journey (https://www.england.nhs.uk/integratedcare/how-did-we-get-here/). It is vital that staff who are at the frontline of shaping and delivering such services have the opportunity to provide their insights and experiences to ensure this journey is as smooth as possible for patients and service providers alike.

Data Availability

The data presented in this study are not publicly available due to confidentiality but are available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Supplementary Materials

Supplementary file 1: consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist. Supplementary file 2: interview topic guide. (*Supplementary Materials*)

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