



**JOINT IMPROVEMENT TEAM  
INTERMEDIATE CARE LEARNING NETWORK**  
—  
**SHARED LEARNING AND DEVELOPMENT EVENT**

**Evaluating Intermediate Care: Services,  
Challenges and Solutions**

**20 September 2007**

## **1. Introduction**

The Joint Improvement Team established a national Intermediate Care Learning Network to support shared learning across health and social care services in Scotland.

As part of this, the Joint Improvement Team (JIT), in association with Information Services Division's (ISD) Joint Future Programme, organised a shared learning event to support health and social care partnerships in evaluating their Intermediate Care developments.

The events aims were to:

- Provide a brief overview of Intermediate Care services in Scotland and the role of the JIT Learning Network;
- Share good practice and experience of evaluating Intermediate Care services;
- Highlight currently available datasets which can be used to inform evaluation;
- Inform partnerships about ISD's Joint Future information programme and the developing Care Assessment Dataset;
- Consider the data requirements for a whole system evaluation of Intermediate Care services.

The event attracted considerable interest across Scotland with participants from health, social care services, the voluntary sector and other organisations, although the majority of participants were from social services.

The programme included an overview from JIT, an update about relevant ISD programmes and a practical guide to evaluation of Intermediate Care initiatives.

Greater Glasgow & Clyde and North Lanarkshire partnerships presented examples of their approach to evaluating supported discharge and integrated day services.

The presentations were followed by a workshop session to consider a toolkit for planning intermediate care services and the case study matrix (see page 9).

## 2. Key Themes from the Presentations

### 2.1 JIT Intermediate Care Learning Network and context for Intermediate Care

Dr Margaret Whoriskey, Assistant Director, JIT  
Dr Anne Hendry, Consultant Geriatrician & JIT Associate

#### 2.1.1 Context

Margaret Whoriskey outlined the context for intermediate care, key drivers for health and social care partnership working, and highlighted the new National Outcomes Framework for community care services, being implemented from 2007/2008.

There are 4 high level outcomes:

- improved health;
- improved wellbeing;
- improved social inclusion; and
- improved independence and responsibility.

These high level outcomes have 16 measures (Table 1):

**Table 1**  
**National Outcome Measures**

- |  |
|--|
| <ol style="list-style-type: none"> <li>1. % of community care service users feeling safe.</li> <li>2. % of users and carers satisfied with care package.</li> <li>3. % of users satisfied with opportunities or social interaction.</li> <li>4. % of user assessment completed to national standard.</li> <li>5. % of carers' assessments completed to national standard.</li> <li>6. % of people 65+ with intensive needs receiving care at home.</li> <li>7. % of people 65+ receiving personal care at home.</li> <li>8. % of carers who feel able to continue their role.</li> <li>9. Shift in balance of care from institutional to 'home based' care.</li> <li>10. No. of patients waiting more than 6 weeks for discharge to appropriate setting.</li> <li>11. % of care plans reviewed within agreed timescale.</li> <li>12. No. of people waiting longer than target for assessment, per 000 population.</li> <li>13. No. of people waiting longer than target time for service, per 000 population.</li> <li>14. No. of emergency bed days in acute specialties for people 65+, per 100,000 population.</li> <li>15. No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000 population.</li> </ol> |
|--|

16. No. of people 65+ admitted twice or more as an emergency who have not had an assessment, per 100,000 population.

These measures incorporate existing targets relating to delayed discharge, repeat emergency admissions and provision of home care services. Achieving a good balance of care will require appropriate and effective 'step up' and 'step down' services (intermediate care) and access to the full range of rehabilitation services to maximise independence and optimise function.

### 2.1.2 Intermediate Care Services in Scotland

A shared definition of intermediate care is contained in the Joint Improvement Team's 'Intermediate Care' Scoping Report 2007<sup>1</sup>. The following definitions from England translate well to the context of Partnership working in Scotland:

*"Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. This includes:*

- *Intermediate care which substitutes for elements of hospital care ('substitutional' care); and*
- *Intermediate care which integrates a variety of services for people whose health care needs are complex and in transition. (complex care)"*

(Oxford and Anglia Intermediate Care Project, 1997)

*"A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care."*

(Making Connections, Change Agent Team, 2006)

Services can be provided in:

- Individual's own homes, sheltered housing and very sheltered housing;
- Day Hospitals, day-care centres and integrated day services;
- Designated beds in care homes;
- Community Hospitals.

These services can include:

<sup>1</sup> <http://www.jitscotland.org.uk/action-areas/themes/care.html>

Rapid response services/supported discharge teams;  
 Intensive care at home schemes;  
 Extra care housing/telecare initiatives;  
 Innovative use of community hospitals;  
 Community assessment and treatment teams.

Intermediate Care Services aim to have the following outcomes:

- Supporting more people at home;
- Reduced time in hospital;
- Increased independence;
- Improved quality of care;
- Reduced admission to residential/nursing home care;
- Faster access to some services;
- Shift in care from acute to community settings;
- Increased provision of local services.

## 2.2 ISD's Joint Future Information Programme

Lorna Jackson and Peter Knight, Heads of Programme, ISD

Intermediate care was considered in terms of the evolving model of care geared towards local, integrated and team based care for people with long term conditions.

<b>Current Model of Care</b>	<b>Evolving model of care</b>
Geared towards acute conditions	<ul style="list-style-type: none"> <li>▪ Geared towards long term conditions</li> </ul>
Hospital centred	Embedded in communities
Doctor dependant	Team based
Episodic Care	Continuous care
Disjointed Care	Integrated care
Reactive care	Preventative care
Patient as passive recipient	Patient as partner
Self Care infrequent	<ul style="list-style-type: none"> <li>▪ Self care encouraged and facilitated</li> </ul>
Carers undervalued	Carers supported as partners
Low tech	High tech

Integrated working underpinned by robust systems to support information exchange would flourish if positioned within a framework which promotes:

- **Partnership development**  
 Joint management /governance /resourcing, CHPs and CHSCPs
- **Improving Practice**  
 Single shared assessment, national outcomes
- **Whole systems**

Wider picture beyond traditional boundaries of health, housing and social care.

- **Monitoring and Evaluation**

Relevant national datasets currently available to support evaluation were illustrated:

- Inpatient discharges:
  - Linkages are possible across systems holding similar data;
  - Length of stay, age, sex, geographies, diagnoses, procedures, specialty;
- Delayed discharge data;
- Outpatient information;
- Community Care data:
  - Day Hospital attendances;
  - AHP activity – imprecise at present;
  - Social work data on personal care at home;
  - Social work data on intensive homecare packages;
- NHS continuing care:
  - SHRUGs (Scottish Health Resource Utilisation Groups);
- Hospital Beds;
- GP Data:
  - QOF (Quality & Outcomes Framework), Practice Team Information (PTI).

Peter and Lorna described the work to develop Assessment & Care Management Information Standards. This work includes standards for care planning, review and carer's information and assessments and will support effective and consistent sharing of information across partners. Professional consensus is required if assessments are to be valid, consistent and useful for evaluation of services.

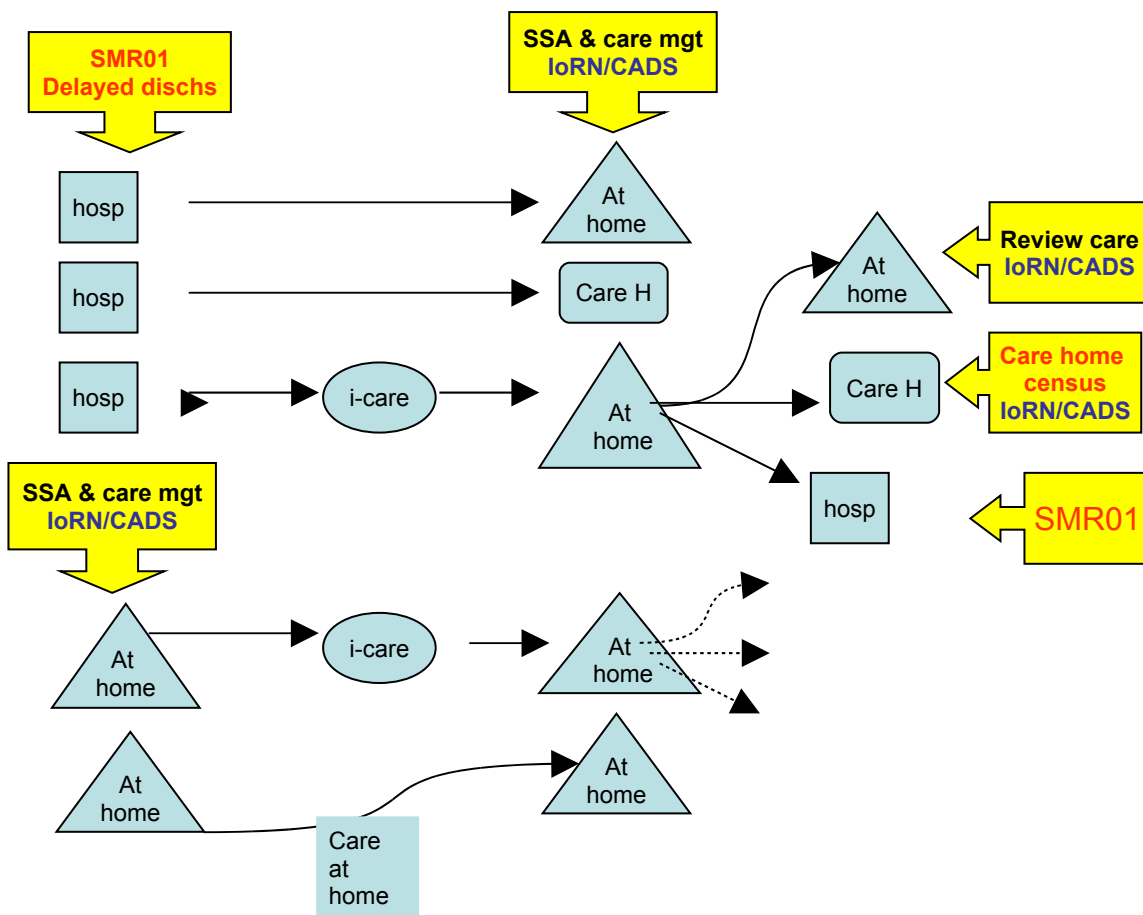
The role of eCare was discussed – ongoing development of ICT solutions to provide real time and secure information sharing between professionals involved in care.

The information being collated for performance measurement against the National Outcomes Framework will be a resource to support evaluating impact of services.

The Indicator of Relative need (IoRN) is collating information, based on most recent single shared assessment, on needs in terms of support for activities of daily living (ADL), personal care, food and drink preparation, behaviour and bowel management. IoRN scores are then grouped as A – I with A representing

low level support needs for ADL, personal care and food/drink preparation and I representing high level support needs for ADL and bowel management.

The Care Assessment Data Summary (CADS) is being developed as a common core minimum data set for community based services with information drawn from SSA identifiers, IoRN and routinely captured information on service users and carers contained in care plans. It is proposed that CADs could be linked with other routinely collected local/national information to provide a whole system information data set that could be used in evaluation and planning of services including intermediate care.



### 2.3 Intermediate Care Metrics: partnership experience of evaluating services

Two partnerships presented their approach to evaluating Intermediate Care services:

*Glasgow* – Fiona Taylor outlined the IRIS supported discharge service and the routinely collected information for service evaluation.

*North Lanarkshire* – Audrey Brogan outlined work in progress to evaluate an Integrated Mental Health and Social care day service

## 2.4 Evaluation – Moving from activity to impact

Alan Gray, Director, Price Waterhouse Coopers

Alan provided the group with some practical advice on evaluation, stressing the importance of deciding early on the appropriate approach and the correct tools.

### Tips:

- Start the evaluation as you prepare the business case;
- Engage with and understand the service in question;
- Clearly define the expected benefits;
- Prioritise and weight the possible benefits;
- Be clear about the measures, how and who will measure them;
- Identify a benchmark to measure against;
- Agree a timeframe and reporting arrangements for the review;
- Consider a staged evaluation to inform and steer future service development;
- Be challenging but realistic;
- Keep it simple.

### Multi-dimensional Approach

Evaluation is commonly multi-dimensional using a dashboard of measures which blend:

- Activity:
  - Increase capacity/throughput;
  - Reducing blockages;
  - Reducing waiting times.
- Process:
  - What improvements will be implemented?
- Experience:
  - How will quality and safety of patient care be evaluated?
- Finance:
  - Is it affordable?

### **3. Workshops**

Four facilitated groups considered the toolkit to support planning and evaluation (Appendix 1) and the case study matrix (Appendix 2), addressing the following questions:

1. **Discuss the matrix and its possible role in planning Intermediate Care services.**
2. **What are the top five data requirements for evaluating Intermediate Care services:**
  - a) **In domiciliary settings?**
  - b) **In residential settings?**
  - c) **In specialist day care settings?**
3. **What local data can be used to systematically measure**
  - a) **Inputs and outputs?**
  - b) **Outcomes?**
  - c) **Whole system Impact?**
  - d) **User and carer experience?**
  - e) **Value for money?**

#### **3.1 Feedback from the Workshop Groups**

- Q.1** The matrix was considered to be a useful planning tool and will assist in identification of gaps. The matrix should remain flexible and partnerships should be able to adapt it to their local needs and service priorities. The layout was considered useful as it offers the opportunity to demonstrate interface of services and any gaps in provision.
- Q.2** The top five data requirements for evaluating Intermediate Care services are:
- a) In domiciliary settings:
    - Reducing dependence on services;
    - Maintaining people at current level of function or better;
    - Home care – number of hours, frequency, ratio of homecare v. personal care;
    - Range of services involved, what they are delivering, why, for how long;

- Patient and Carers views.
- b) In residential settings:
- Functional dependency levels;
  - Changes in dependency – positive and negative.
- c) In specialist day care settings:
- Clarity on what the specialist setting is providing;
  - Data on people who attend – usual care data set;
  - Throughput;
  - Changes in case mix over time;
  - Impact / benefit to carers where relevant.

**Q.3** Local data can be used to systematically measure:

- a) Inputs and outputs:
- Range of services provided, nature and level – e.g. Angus single outcomes framework;
  - Range of existing performance targets – local and national.
- b) Outcomes:
- Wide range of condition specific functional/clinical measures;
  - User / carer satisfaction including the UDSET;
  - National Community Care Outcome Measures.
- c) Whole system Impact:
- Not yet well developed but agree role for CADS in future.
- d) User and carer experience:
- Questionnaires and focus groups.
- e) Value for money:
- Constrained by lack of joint resourcing infrastructure.

**The top three action points/points of note from the workshop groups**

Group 1:

- Embed evaluation in Integrated Care Plans;
  - Use SPARRA data;
  - Share feedback from pilot projects;
  - Consider differing expectations of users, carers, providers;
  - Whose outcomes?

Group 2:

- Opportunity to review in more detail and feedback comments;
- Define day care (range of services);
- Use of IoRN in care homes: eligibility criteria?

## Group 3:

- Attempt longer term follow up;
- Describe the service baseline;
- Capture the changing landscape;
- Reflect change in service use and balance of services;
- Ask right questions from the start.

## Group 4:

- Completing planning toolkit is a useful stage of evaluation;
- Difficult to directly connect cause and effect;
- Capture the contribution of unpaid carers.

### 3.3 Further Issues

A number of other more general issues were raised by the groups, including:

- Concept of 'unpacking the Black Box'. Difficulty determining which particular service(s) actually makes the difference where a number of services are involved across the system or at various stages in the pathway.
- Prevention work and early intervention is necessary but very difficult to accurately measure impact due to the long lead time for tangible benefit. Coventry City example of good practice was offered.
- Identification of the critical component parts of services and finding valid ways of measurement can be challenging
- Differences in cost of delivery of services between urban and rural settings was noted and considered to be an issue, particularly when comparing services across partnerships.

## 4. Summary and next steps

### 4.1 Learning Points

Anne Hendry concluded with a short summary of key learning points from the day:

- Use of available and emerging national information resources;
- Opportunity to pilot CADS in Intermediate Care cohort;
- Further work may be required on IoRN to refine sensitivity for dementia needs;
- Data to support medication management;
- Embed evaluation for ownership to drive service improvement;
- Stage evaluation (Action Research approach);
- Be SMART – embed measures in process of service delivery;
- Use data to secure funding, assure quality, reassure service users, carers and staff and change attitudes and practice;
- Evaluation needs to reflect dynamic evolving nature of services;
- Capture team ethos / development;
- Single intervention = simple evaluation;
- Network of complex personalized services = multidimensional approach to evaluation;
- Capture impact on carers;
- Creative and cross cutting approach for measuring participation and wellbeing.

### 4.2 Next steps

Report and Presentations will be posted on Joint Improvement Team website.

There will be emerging opportunities for JIT and ISD to work with partnerships as evaluation experience grows.



## **Intermediate Care Services**

### **A Toolkit for Planning**

*Intermediate Care is a range of integrated services to promote faster recovery from illness, prevent inappropriate acute hospital admission, support timely discharge and maximise independent living. It can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team.*

*Intermediate Care is a service provided on a short term basis at home or in a residential setting for people who need some degree of rehabilitation and recuperation at times of transition in their health, social or housing needs. Its aims are to optimise independence, reduce delayed discharge and prevent premature admission to long term residential care. The duration of interventions will be dependent on the needs of individuals and the nature of their condition(s).*

### **Components of Intermediate Care Services in Scotland**

This toolkit sets out the key components of intermediate care services currently provided in a range of settings and facilities across Scotland. It is not expected that each intermediate care service will include all components. The relevance and importance of each component will depend on local system pressures and on the service infrastructure already provided by NHS, Local Authority and Voluntary Organisations.

### **Toolkit for Planning**

The toolkit includes a number of self assessment matrices that have been developed as a tool for strategic planners from health and care partnerships and for use by Intermediate Care service managers.

Partnerships, planners and managers of Intermediate Care services should consider the extent to which the key components are included in current service provision. The completed matrices can then be used to identify potential service gaps and areas which require further links with existing acute, and community services and with voluntary providers.

The self assessment toolkit is arranged in 4 sections:

- Service Purpose *page 15*
- Organisation and Delivery of Intermediate Care services *page 16*
- Management of Intermediate Care services *page 21*
- Evaluation *page 23*

**How to use this Toolkit**

The matrices in this toolkit can be completed by any group involved in planning, commissioning and delivering Intermediate Care services. It will be of most value however if it is completed jointly by all groups involved in the process. Whilst completing the matrices will provide a useful stock-take of current service provision, the discussion generated through multi-professional completion will increase collective understanding and will illuminate areas where there is lack of clarity and a need for further consideration.

## SECTION ONE: PURPOSE

This is the key area for all those involved in planning and provision of Intermediate Care services to consider. Completion of this matrix will enable discussion about what the service is aiming to achieve for individuals and for the organisation. Although at first glance all the aims may seem relevant, further exploration will highlight priorities and will help to ensure that expectations are explicit and understood. Developing an agreed purpose is also important in being able to evaluate the outcomes of the service.

### Purpose of the Service

#### Key Questions:

- Why was the service established?
- Are all the service aims equally important?
- Do some have higher priority?
- Are there gaps?
- What should be done to address these?

Aims	Very Important	Quite Important	Of little Importance	Not Relevant
To support more people at home				
To offer an alternative to admission to hospital				
To enable faster discharge from hospital				
To increase independence				
To provide ongoing rehabilitation				
To provide a more appropriate care setting				
To provide faster access to community services				
To shift care from acute to community settings				
To reduce admissions for long term residential care				
To enhance local provision of services				
To reduced need for long term support packages at home				
To focus on people at times of transition in their needs				
To offer time limited interventions				
To deliver more integrated services				
To provide a clear pathway through services				
Other				

## SECTION TWO: ORGANISATION AND DELIVERY

The matrices in this section look at the components of service delivery including the settings where Intermediate Care services might be provided; how people can access or be referred to the services; the client group and any eligibility criteria; and the staffing required to deliver the service.

### Range of Settings for Service delivery

#### Key Questions:

- Are other parts of the organisation/partnership already providing services in these settings?
- How do we ensure effective links with these other service providers?
- Should we consider a wider range of settings for delivering the Intermediate Care service?
- What would be required to extend the range of settings?
- What benefits would there be?

<b>Setting</b>	<b>Always delivered in this setting</b>	<b>Sometimes delivered in this setting</b>	<b>Never delivered in this setting</b>	<b>Not relevant as provided in this setting by another service</b>
Individual's own home				
Sheltered / very sheltered housing ( where the IC service user is not usually resident )				
Day Centre / Resource centre				
Day Hospital				
Residential Home				
Nursing Home				
Community Hospital				
Other				

**Accessing the Service****Key Questions:**

- What interventions are available as part of the service
- Which of these are available out of hours?
- How are referrals made?
- Is there an operational policy?
- Are referral and transfer protocols clear?
- Do protocols promote consistent standards and practice?
- Do service users and referring agencies understand the aims and pathways?
- Is there equitable access to services across the partnership?

<b>Service</b>	<b>Available out of hours</b>	<b>Readily available in hours</b>	<b>Limited availability in hours</b>	<b>Not available</b>
Community assessment and treatment team				
Community rehabilitation team				
Rapid response service				
Crisis care				
Early supported discharge				
Community based falls prevention service				
Intensive care at home schemes				
Intermediate Care in sheltered / very sheltered housing				
Day centre / resource centre				
Residential Intermediate Care in care home setting				
Intermediate Care in a community hospital				
Telecare (including community alarms)				
Other				

**Who can refer?****Key Questions:**

- Is it a 'push system'?– referrals are reactive / initiated outwith the IC service
- Is it a 'pull system'? – IC service seeks referrals through proactive contact
- How are referring groups informed about the service?
- How is feedback provided on appropriateness of referrals?
- How could the referral process be made more streamlined?

<b>Referring agency / practitioner</b>	<b>IC Service offers a systematic 'Pull system'</b>	<b>fax / electronic referral</b>	<b>Phone referral</b>	<b>No direct access</b>
Social Worker				
Care manager				
Home care manager				
Care Home manager				
Community nurse				
Case / care manager				
Community based AHP				
GP				
A&E				
Acute admissions unit				
Stroke team				
Geriatric Orthopaedic ward				
Medicine for the Elderly wards				
General medical / surgical wards				
Day centre staff				
Day hospital team				
Out of Hours services				
Hospital Discharge teams				
Other				

**Caseload / Client Group****Key Questions:**

- Are eligibility criteria explicit?
- Are certain groups excluded?
- Do other staff / resources / expertise already care for these excluded groups?
- What other case group(s) could be included?

<b>Client Group</b>	<b>Service specifically for this group</b>	<b>Usually eligible</b>	<b>Only selected individuals</b>	<b>Excluded</b>
Younger adults ( <65s)				
Older adults ( >65s)				
Frail older people				
Orthopaedic rehab				
Stroke Rehab				
COPD/ Pulmonary rehab				
Post surgical rehab				
Amputee rehab				
Recurrent fallers				
Acquired brain injury				
People suitable for rehabilitation				
People with Learning Disability				
People with mild dementia				
People with moderate / severe dementia				
Individuals in need of planned respite care				
Individuals in need of Emergency respite care				
People with palliative care needs				
Other				

**Staffing****Key Questions:**

- What is the most appropriate skill mix?
- Are there opportunities for extended roles for this group of staff?
- Is training multidisciplinary? Is training interagency?

<b>Staff</b>	<b>Core team member</b>	<b>Systematic liaison role but not in core team</b>	<b>Named individual available when required</b>	<b>No role identified</b>
Nurse				
Physiotherapist				
Occupational Therapist				
Rehab support worker				
CPN				
Dietitian				
S&LT				
GP				
Consultant				
Social worker				
Home care staff				
Staff training support				
Other				

### SECTION THREE: MANAGEMENT

These matrices enable you to consider how the services is funded, and how the Intermediate Care service fits alongside other services provided by health, social care and voluntary organisations. Completion of this matrix will enable planning and delivery groups to consider any duplication or overlaps in services and to identify where there are gaps in current service provision.

#### **Service Funding Stream(s)**

#### **Key Questions:**

- Is funding fixed term or recurrent?
- Is a cost benefit analysis required to secure funding?
- What funding opportunities may support change / development?
- How best could short term funding be applied?

<b>Funding</b>	<b>Completely / almost completely</b>	<b>Partially / joint funding</b>	<b>A Little</b>	<b>Not Relevant</b>
NHS Funding				
Local Authority Funding				
Resource Transfer				
Winter pressures money				
Funding from service redesign				
Core funding				
Short term funding				
Other				

**Communication with Other Services****Key Questions:**

- How smooth is the transition for service users?
- How is information passed between service providers?
- Are there agencies and organisations not yet fully engaged?
- How can they be more fully engaged?

<b>Service</b>	<b>Full engagement and information exchange</b>	<b>Limited engagement or information exchange</b>	<b>Distant partner</b>	<b>Currently no link</b>
Rapid Response				
Care Management				
Home Care				
Community alarms				
Joint store				
Community OT				
Community nurses				
Community Mental Health Team				
A&E				
GPs				
Out of hours service				
Day hospital				
Acute hospital services				
Housing agencies				
Care homes				
Voluntary organisations				
Other				

## SECTION FOUR: EVALUATION

This is a complex area of work. Most commissioners and providers agree that it would be nice to have a straightforward system that could demonstrate the comparative cost-effectiveness of different models of Intermediate Care provision. In reality however, the majority of services have developed to meet a specific and pressing local need and their effective operation and delivery is dependant on the interaction with other health care, social services and voluntary organisations.

Evaluation of Intermediate Care services in England identified broadly that there was a high level of user satisfaction and good outcomes from residential based services, and that non-residential models of Intermediate Care offered significantly lower costs.

In Scotland, the information collected within most Intermediate Care services is valuable and robust, however it concentrates on aspects of the service related to the care provided within the service, for example:

- Referral rate / sources
- Adherence to protocols
- Utilisation of resources
- Monitoring of individual care plans
- Patient / client satisfaction
- Changes in the requirements for ongoing support

Data collection commences with the referral for admission and is completed shortly after discharge from the service (home or to alternative care). There is a risk that although Intermediate Care services may produce evidence of high quality of care and good outcomes for individuals, it may not demonstrate how these services relieve pressure on the acute sector, or how it impacts upon the costs of long term independent support services and care.

Developing a clear understanding of the aims of the service (section one) will enable a better directed collection of relevant data.

### **Evaluation of Intermediate Care Service**

#### **Key Questions:**

- What does success look like?
- What should we measure?
- How can that measurement be embedded in the service?
- Where can comparative data be accessed?

<b>Information / Data</b>	<b>Prospectively captured</b>	<b>Easily accessed retrospective</b>	<b>Occasionally accessed or with difficulty</b>	<b>Currently not able to be measured</b>
Referral rate / sources				
Level of unmet need				
Adherence to protocols				
Monitoring of individual care plans				
Duration of intervention				
Nature of intervention				
Baseline mobility, independence and function				
Mobility, independence and function at discharge from IC				
Destination at transfer from service				
Patient / client experience				
Change in need for ongoing support				
Longer term outcome and support needs				
Comparatives outcome analysis				
Bed days utilisation				
Readmissions				
Cost benefit analysis				
Impact on Carers				
Other				

## Intermediate Care Services

### Definitions of Intermediate Care

*Intermediate Care is a range of integrated services to promote faster recovery from illness, prevent inappropriate acute hospital admission, support timely discharge and maximise independent living.*

*It can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team.*

*Intermediate Care is a service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care.*

*By definition, services will be time-limited and timescales will be dependent on the needs of individuals or patients and the nature of the individual's condition.*

### Intermediate Care Services in Anyarea\*

This matrices in this report sets out the key components of intermediate care services provided in a range of settings and facilities across Scotland. For each of the defined intermediate care services in Anyarea, there is an indication regarding the extent to which key component are included in current service provision.

It is not expected that any integrated care service will include all components – the relevancy and importance of each will depend on local pressure and the provision of other services by the NHS, Local Authorities and Voluntary Organisations.

Individual organisations could use the matrix to consider areas where they do not currently provide components of the service and to determine whether there is a case for them to do so, or how they might link with other parts of the community currently providing these services.

\* Anyarea is a fictional composition of health and local authority areas

Who was involved in completing this matrix:

NHS Head of Community Planning

Director of CHP 1

Assistant Director CHP2

Manager IC service A

Manager IC service B & F

Manager of hospital X rapid response team

Director of Rehabilitation and AHP

Team Leader IC service D

Assistant Director of Social Work, Head of Adult Services

**Overall Purpose / Outcomes**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Supporting more people at home		++	++	+	++	+++
Alternative to hospital admission	+	++	+++	+++	+++	+++
Faster discharge from hospital (avoid delayed discharge)	+	++	+++	+++	+++	++
Increased (maintained) independence	+	+++	+++	+++	+++	+++
Ongoing rehabilitative approach		+++	++	++	++	+++
Improved quality of care (appropriate care setting)	+	++	++	++	++	+++
Faster access to some services		+	+	+	+	+
Shift in care from acute to community settings	++	++	++	++	++	++
Reduced admission to residential/nursing home		+	++	+	++	++
Increased provision of local services	++	++	++		++	+++
Reduced packages of care at home	+	++	++	+	++	+
Focus on people in transition	+	++	+++	+++	+++	+++
Time limited interventions		++	++	++	++	+
Integrated services	+++	+++	++	+	+	++
Clear patient pathway through services						

blank: not relevant    + of little importance    ++ quite important    +++ very important

**Range of Settings**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Individuals own homes						++
Sheltered / very sheltered housing						?
Day Centres		+				?
Day Hospitals						?
Residential Homes						
Nursing Home	+	++	+++	+++	+++	+
Community Hospital	+++					

Blank: not relevant    + never delivered in this setting    ++ sometime delivered in this setting    +++ always delivered in this setting

**Accessing Intermediate Care Services**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Community assessment and treatment teams						+
Community rehabilitation teams						
Rapid response services						
Crisis care						
Early supported discharge		+				+
Community based falls prevention service						+
Intensive care at home schemes						+
Sheltered / very sheltered housing						
Telecare (including community alarms)						
Residential Intermediate Care facilities in care home	++	+++	+++	+++	+++	+
Day centre / resource centre						
Alternative use of nursing at home provision					++	
Use of community hospital facilities	++					
Extended primary care teams						+

Blank: not available + limited availability in hours ++ readily available in hours +++ available out of hours\_

**Referral source**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Social Work	+	++	++	++	++	++
Care manager	+	++	++	++	++	++
Home care manager						
Care home manager						
Community nurse						
Community AHP						
GP / Primary Care team	++	++	++	++	++	++
Older people's services	++	++	++	++	++	++
A&E	++	++	++	++	++	++
Acute Admissions Services	++	++	++	++	++	++
Stroke team	+					+
Geriatric Orthopaedic ward	+	+	+	+	+	+
Medicine for the elderly wards	+	+	+	+	+	+
Day centre staff						
Day hospital team						
Out of hours service	+	+	+	+	+	+
Hospital Discharge teams	+	++	++	++	++	++
Other						

Blank: no direct access    + phone referral    ++ fax / electronic referral    +++ IC proactive in seeking referrals

Client group

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Younger adults	+					+
Over 65	+	+	+	+	+	+
Frail older people	++	++	++	++	++	++
Orthopaedic rehab	++	++	++	++	+++	++
Stroke Rehab	++	?	?	?	?	
COPD / pulmonary rehab						
Post – surgical rehab	++	++	++	++	++	++
Amputee rehab	+					
Persistent fallers	+	++	+++	++	++	++
Acquired brain injury						
People requiring further assessment	++	+			++	+
People suitable for rehabilitation	++	++	+++	+++	++	+
People with Learning Disability						
People with moderate / severe dementia	++	+				+++
Planned respite						
Emergency Respite	?	+				+++
People with palliative care needs	++	?				

Blank: excluded    + only selected individuals    ++ usually eligible    +++ service specifically for this group

**Staffing**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Nursing	+++			++		
Physio	++	++	++	++	++	++
OT	++	++	++	++	++	++
Rehab support worker						
CPN	?					+++
Dietetics	+	+			+	
Speech and language						
GP	++	++			++	?
Consultant	++		+			
SW		++	++		++	++
Home Care staff	++	++	++	++	++	++
Staff training		+	?	?	+	++

Blank: no role identified    + skill available when required    ++ systematic liaison role    +++ core team member

**Links with other services**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Care Management	++	++	++	+	++	++
Home Care	++	++	++	+	++	++
Community alarms		?	?		?	
Joint equipment store						
Community OT			+		+	
Community nursing / district nursing	++	+	+	++	+	?
Community mental health team						+
A&E	++	+	+	+	+	++
GPs	++	+++	+++	+	+++	++
Out of hours service						
Day hospital						
Acute Hospital services	++	++	++	++	++	++
Housing agencies						
Residential homes	++	+	++		+	
Voluntary organisations		+				+

Blank: currently no link    + distant partner    ++ limited engagement or information exchange    +++ full engagement and information exchange

**Funding**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
NHS Funding	+++		+	+++	+	+
Local Authority Funding		+++	++	?	++	++
Resource Transfer	?	?	?	?	?	?
Winter pressures money	+	+	++		++	
Funding from service redesign					++	++
Core funding	+++	++	++	++	++	?
Short term funding					+	

Blank: not relevant    + a little    ++ partially / joint funding    +++ completely / almost completely

**Evaluation**

	IC Service A	IC Service B	IC Service C	IC Service D	IC Service E	IC Service F
Referral rate / sources	+++	+++	+++	+++	+++	+++
Level of unmet need						+
Adherence to protocols	+	+	++	++	+++	+
Utilisation of resources	+	++	+++	+++	+++	++
Monitoring of individual care plans	+++	+++	+++	+++	+++	++
Duration of intervention	++	++	++	++	++	++
Nature of intervention	+++	++	++	++	++	+
Baseline mobility / function		+++	+++	+++	+++	+
Mobility / function at discharge		+++	+++	+++	+++	+
Destination on discharge						
Patient client satisfaction	+++	+++	+++	+++	+++	
Changes in requirements for ongoing support		+	++		++	
Long term follow up						
Comparatives outcome analysis						
Bed days utilisation	++	++	++	++	++	
Readmissions	+		+	+		
Cost benefit analysis						
Impact on Carers					+	+

Blank: currently not able to be measured    + occasionally accessed with difficulty    ++ easily accessed retrospectively    +++ prospectively captured