

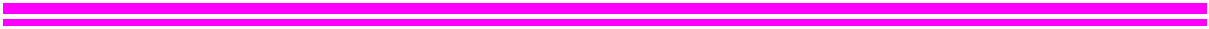
Intermediate Care & Rehabilitation Project

Waverley Intermediate Care Pilot

Final Evaluation Report

April 2009

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1.0 Introduction

- 1.1 The shared principles of Changing Lives (SE2006) and Delivering for Health (SE2005) direct a shift in the way that services are delivered, with a greater emphasis on self care and independent living.

The reports identify the need for change in the ways that services are delivered, with shifts to inter-agency service redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling.

- 1.2 Co-ordinated, Integrated and fit for Purpose: A delivery Framework for Adult Rehabilitation (SE 2007) now places rehabilitation at the core of service redesign.

The priority for NHS Boards and local authorities will be to:

- Transform their rehabilitation services to put rehabilitation at the heart of service delivery
- Adopt a whole systems approach to rehabilitation services
- Give greater priority to rehabilitation services
 - Reflect evolving outcome measures for community care (and any subsequent target) that impacts on rehabilitation services

- 1.3 Key messages from Better Outcomes for Older People (SE2005) which are a continuing theme today are about:-

- Proactively supporting older people living at home so that they are not inappropriately admitted to hospital or a care home
- Providing intensive rehabilitation prior to returning home from hospital
- Ensuring a seamless transition from hospital to home
 - Facilitating provision of appropriate rehabilitation support to people in care homes
 - Actively supporting older people and their carers on returning home from hospital

- 1.4 Intermediate Care in Scotland A Partnership Approach is a scoping report produced by the Joint Improvement Team (JIT) in June 2007. It states that

“an increasing number of intermediate care projects are being developed by partnerships in Scotland...whilst there is no specific national strategy or guidelines for intermediate care in Scotland, recent policy is directing the development of services to support people as far as possible in their own communities in the context of a whole system approach.”

The JIT report also states that

“The success and effectiveness of Intermediate Care services depends upon the range of existing services, including social work services, the extended primary care team and the role of acute and community hospitals. Where services report their greatest successes, it is where the interface between intermediate care services and other hospital or community services are well managed.”

1.5 Definitions (provided in JIT report):

Intermediate Care: “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 discharge and prevent premature admission to residential care.” (Making Connections, Change Agent Team, 2006)

Rehabilitation: “A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients and service users, and their family carers.” (Kings Fund 1998)

1.6 Over the past year, Scottish Borders Council has been carrying out a Best Value Review of Older Peoples Services. A work stream within this review is the Intermediate Care and Rehabilitation Project. A work stream within this project is the development of an intermediate care (IC) resource that will deliver intensive rehabilitation based on the above definitions.

1.7 In 2007/2008 the planning and redesign of an eight bedded wing of Waverley Residential Care Home to provide a seven bed intermediate care resource was completed. This involved the moving of residents from one wing of the home to another to free up the eight beds. This was achieved through the goodwill of the residents and their families and carers and their recognition of the value of such a service. An option appraisal was also carried out to agree funding/provision of staff resources (appendix1). It was agreed that Occupational Therapy and Physiotherapy input be provided by the Rapid Response Team to assess clients’ rehabilitation needs and devise treatment programmes which the Social Care Assistants/Workers from within the residential care home would implement. Two case studies are included within the attachments of this report and three within the attached Interim Evaluation Report to illustrate clients’ that have benefited from the Intermediate Care Service from admission to Waverley IC Unit to their return home, (appendices 2, 3 & 5). A breakdown of full costs including staffing resources is also included (appendix 4). This new service was launched on the 26th May 2008 and will run as a twelve month pilot to explore the viability of such a service as a future model of service delivery.

1.8 A robust interim evaluation of the service was carried out in October 2008 with early recommendations made (appendix 5). This was a

comprehensive evaluation which covered the period 26th May to 30th September 2008. It demonstrated that this is a valuable service which fills a previous gap in the continuum of care and enables positive outcomes for clients. The interim report provided early indications on the impact on services, implications for budgets for both SBC and NHS Borders and how these budgets need to be developed to shift the balance of care.

- 1.9** The Waverley IC pilot is due to end on the 26th May 2009. The reviewing stage for the Transforming Older Peoples Services (TOPS) programme finished on the 31st March 2009. The final report for the Waverley IC pilot will therefore coincide with the overall reporting structure for the TOPS programme as a whole.
- 1.10** The interim Waverley IC report was carried out only five months previously therefore it is not the intention of this report to fully replicate that evaluation process. The statistical data already collected for the interim report will be added to and reported on for the period 26th May 2008 to 31st March 2009 within this report.
- 1.11** Information for this report has been gathered using the existing data collection and recording tools, client feedback questionnaires, outcomes from the validated client dependency rating tool with an emphasis on post discharge outcomes from Waverley IC. There is an emphasis on the development needs of the service which will provide a framework should this model of service be replicated in other local authority care homes in the Scottish Borders, and, key recommendations made.

2.0 Statistical Data

2.1 Admissions

From 26th May 2008 to 31st March 2009 there have been 51 admissions, figure 1. The unit has been consistently under demand and has been full on three occasions. The 85% occupancy rate has proved an effective system for bed management. The unit did attempt to open an eighth bed for emergencies however this was unmanageable due to staffing capacity and is no longer available.

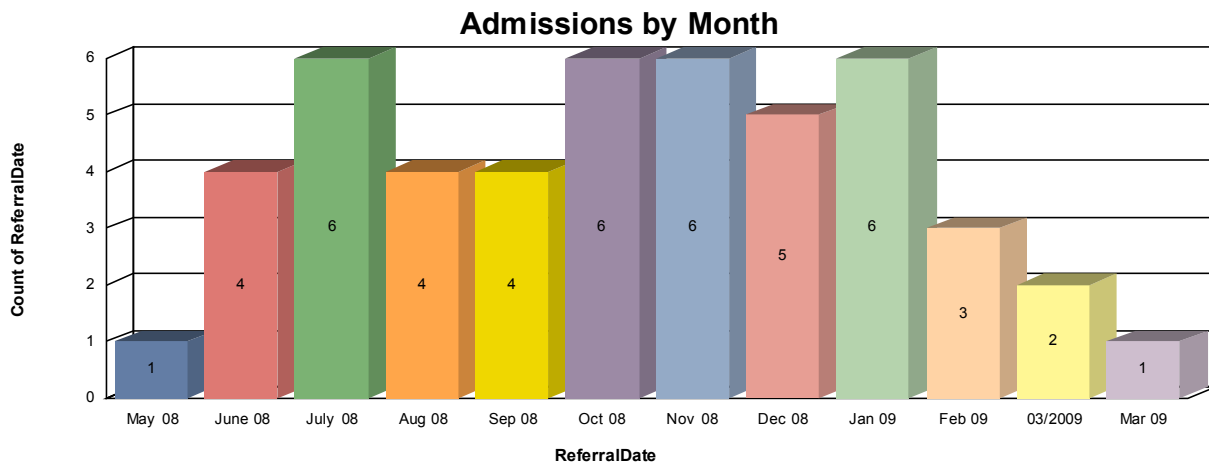


Figure 1

| Occupancy Rates 26/05/2009 - 31/03/2009 | | |
|------------------------------------------|---------------|--------------|
| Area | No of Clients | Bed Days |
| Eildon | 46 | 1265 |
| Kelso | 1 | 47 |
| Teviot | 2 | 69 |
| Tweeddale | 2 | 75 |
| Total | 51 | 1456 |
| Total bed days available (6 beds) | | 1860 |
| % occupancy rate | | 78.3% |

Table 1

The figures in Table 1 demonstrate the locality areas in which the clients that have been admitted to the IC unit normally reside. The majority of clients, 46, come from the central Borders area (Eildon). The table also shows the number of bed days used by those clients eg Eildon residents have a total bed days of 1265. It would be a fair assumption that the reason for so few residents of areas out with the Eildon not using the IC unit is that it is not within their own communities. This would provide an argument for making better use of local community resources either within or associated to locality areas. The overall occupancy is 78.3%. This is based on a seven day week and includes public holidays. It has been calculated over six beds which is based on the 85% occupancy rate formula, (Appendix 10 Bed Management).

2.2 Reason for Referral

Of the 51 admissions, 13 prevented a hospital admission, 32 facilitated a hospital discharge and 6 prevented an admission to permanent residential care home, figure 2.

Figure 2

2.3 Referrer

Of the 51 admissions, 18 were from BGH, 12 from Social Work Teams, 9 from Rapid Response, 5 from GPs, 2 from A&E, 2 from Community Hospitals, 1 from District Nurse, 1 from Discharge Liaison Team (DLT) and 1 from Other. It should be noted that DLT make a significant contribution to the Borders General Hospital (BGH) ward referrals to Waverley (captured under Acute) therefore DLT's 1 referral does not reflect the partnership approach they have with the wards of the BGH or with Rapid Response.

2.4 Diagnosis

Figure 3

The diagnosis of those that used the service is categorised by the main presenting illness, condition or disability at the point of referral. Of the 51 referrals, there were 20 orthopaedic/falls, 18 mobility, 5 medical, 4 surgical, 2 neurological (stroke), 2 respiratory, figure 4.

Figure 4

2.5 Average Length of Stay

The average length of stay overall is 28 days. This has reduced by 1.7 days since October 2008. Figure 5 breaks this figure down according to the main presenting condition, disability or illness at the time of admission. It should be noted that the neurological category's above average length of stay was due to a client who was waiting for permanent care home placement. The average length of stay overall was also increased due to another client waiting for appropriate housing in the community.

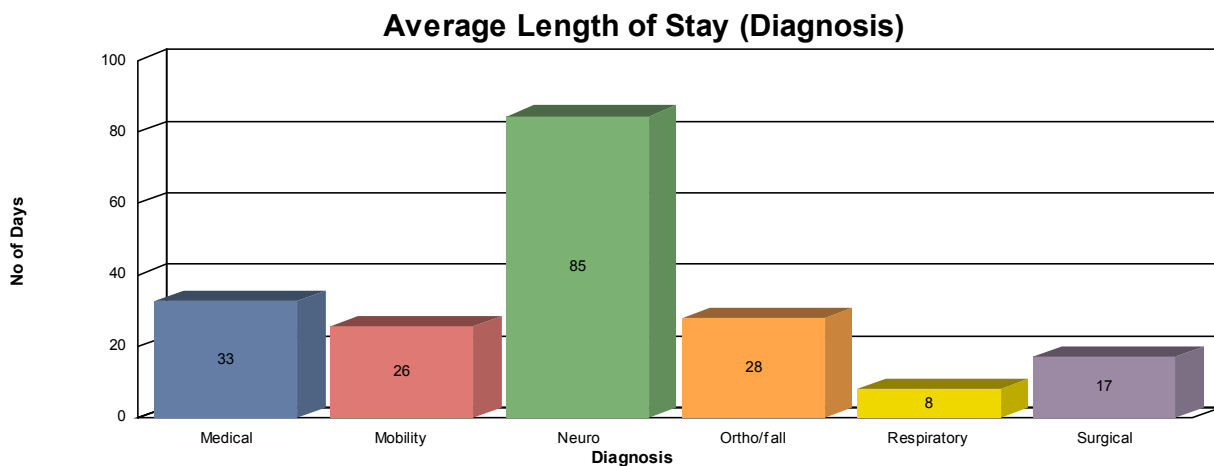


Figure 5

The average length of stay in relation to reason for admission suggests that individuals coming in to the IC unit straight from home overall spend less time in the unit, figure 6. This could be due to people who are admitted from their own home direct to hospital need a period of recovery following an acute illness. However there is a wider question around whether hospital environments are conducive to good rehabilitation or create a culture of dependency?

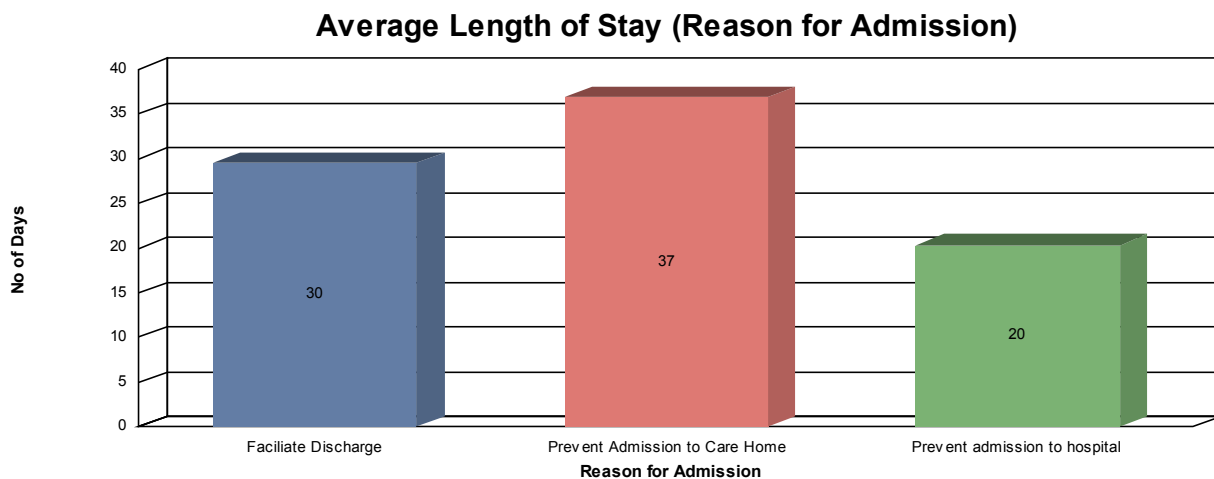


Figure 6

2.6 Average Dependency Score

The Pulses dependency scoring tool is a validated tool which was already being used by the Rapid Response team before the IC unit was opened. It was agreed at the outset of the pilot that this tool would be used for the purposes of the pilot as the staff were already familiar with its use. However it is recognised that any one tool has its limitations and that perhaps a more useful approach to measuring outcomes for individual need would be a 'basket' of tools that can measure more specific needs. This development is now underway. The average fall in dependency whilst admitted to the IC unit decreased from 12 to 10, figure 7.

Figure 7

2.7 Discharge Outcome

Of the 51 admissions, 36 were discharged to their own home, 7 were admitted to hospital, 2 were admitted to permanent residential care homes, 1 returned to stay with family, 1 died, and 1 discharged to respite facility, figure 8. At the time of this report 3 were not yet discharged from the IC unit therefore not accounted for within this tables figures.

Figure 8

2.8 Average size of care package

The average hours of care package have shown an increase on discharge from the unit, figure 9. Although some clients have required additional support, it has allowed individuals to return to their own homes safely, confidently and as independently as possible.

Figure 9

In the first phase of the pilot the average size of care package nearly doubled on discharge from the unit. This has improved significantly since the interim report. This could be due to the skills of the IC team as a whole improving over that second period.

3.0 Pulse Score outcomes post discharge

3.1 There appears to be a lack of research to demonstrate the effectiveness and long term benefits of intensive rehabilitation once an individual has returned home following a stay in an intermediate care resource. This area was therefore included in the evaluation process. At the start of the pilot it was anticipated that clients would be evaluated 3 monthly and 6 monthly post discharge from the unit. Unfortunately this information was not collected until after the sixth month period. Therefore comparisons between 3 and 6 months cannot be made. Data was collected on 23 clients and is presented in figure 10.

Intermediate Care – Pulse Scores

| Name | No. of days In IC | Pulse score | | | Comments |
|------|-------------------|---------------|------------------|-----------|-------------------------------------------------|
| | | Pre admission | During admission | At review | |
| Xxxx | 13 | 11 | 9 | 6 | |
| Xxxx | 47 | 10 | 8 | 7 | |
| Xxxx | 33 | 15 | 10 | 10 | |
| Xxxx | 24 | 20 | 18 | 16 | |
| Xxxx | 127 | 11 | 10 | 10 | |
| Xxxx | 1 | 13 | 13 | 6 | |
| Xxxx | 30 | 16 | 14 | 13 | |
| Xxxx | 20 | 19 | 16 | 21 | Nursing Care |
| Xxxx | 35 | 12 | 9 | 9 | |
| Xxxx | 21 | 15 | 13 | 15 | Mental health issues, awaiting residential care |
| Xxxx | 17 | 10 | 8 | 8 | |
| Xxxx | 27 | 11 | 7 | 7 | |
| Xxxx | 56 | 18 | 22 | 22 | Medical complications |
| Xxxx | 31 | 13 | 10 | 10 | |
| Xxxx | 44 | 15 | 13 | 20 | Medical relapse |
| Xxxx | 24 | 14 | 12 | 16 | Dementia progressed, await residential care |
| Xxxx | 47 | 13 | 8 | 8 | |
| Xxxx | 39 | 16 | 14 | 18 | |
| Xxxx | 78 | 18 | 13 | 12 | |
| Xxxx | 21 | 13 | 12 | 12 | |
| Xxxx | 44 | 13 | 9 | 7 | |
| Xxxx | 47 | 15 | 12 | 12 | |
| Xxxx | 18 | 12 | 9 | 7 | |

Lowest dependency score possible = 6/24

Highest dependency score possible = 24/24

Figure 10

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-
- 3.2** Of the 23 clients, 17 have retained or improved their independence levels since leaving the IC unit. Of those 17, 8 demonstrated continued improvements and 10 retained their same level as on discharge. 5 demonstrated an increase in their dependency levels, 3 of whom now require residential/nursing care, 1 due to an exacerbation of their medical condition and 1 no reason was given. Of the 3 requiring residential care 1 was due to progression of dementia, 1 was for mental health issues (not specified), 1 for nursing care. It is unclear at the time of writing this report whether residential care is required due to lack of resources in the individuals own home or whether safety is such an issue that residential care is the only alternative. Further exploration of these cases could provide an opportunity to identify if resources are indeed in the correct place to allow people to continue living in their own homes.
- 3.3** The Pulse Score outcomes clearly demonstrate medium to long term benefits for individuals returning to their own homes. The Waverley IC unit cost per week is £983, appendix 6. This may be considered to be an expensive service at the point of delivery however it can be argued that given the positive outcomes for clients over the longer term eg increased independence, confidence and safety this prevents individuals presenting to acute and community services eg A&E, social work, Rapid Response, Community Hospitals etc in the short term therefore having a positive impact on budgets overall.
- 3.4** It should be noted that Waverley IC unit cost remains cheaper in comparison to NHS bed based models as demonstrated in the Waverley Interim Evaluation Report (appendix 5 P.17), for updated costs refer to http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=Costs_R300s_2008.xls&pContentDispositionType=inline

4.0 Client Questionnaires/feedback

- 4.1** The client questionnaires have provided qualitative feedback on their experience of their stay in Waverley. 26 questionnaires have been returned (51% of all admissions). The questionnaires indicated clearly that clients were happy with the service they received in the unit. Clients felt that they achieved the aims of their rehabilitation, improved their ability to carry out activities at home, increased their confidence and felt safer and more able to support themselves at home. Clients also felt that their length of stay was about right. The majority of clients received an IC leaflet however one client who did not suggested that more information was required. Since October 2008 interim report (appendix 5) two clients suggested that a shower was required and there were no negative comments regarding the food, indeed, one client stated “good soup”. There were three negative comments as stated below.

4.2 Best thing about my stay:

“Consideration was always given to me returning home”

“Well trained in rehabilitation”

“Everything”

“The care in Waverley Care was 1st Class and all carers were really so kind and helpful to me”

“Has been the care, support which I have had since I came in, which has enabled me to be ready to go home and cope on my own – many thanks to everyone”

Worst thing about my stay

“Boredom”

“Getting on my socks”

“Some residents not very clean or hygienic in toilet. Staff usually quick to respond”

- 4.3 In addition to the client questionnaire feedback there have been many positive verbal comments to staff about the valuable service Waverley IC unit provides. In addition some clients have put their praise in writing, one to a local paper and some in writing to the department. The letter below best represents these comments. This is also followed by an email provided from a social worker care manager on behalf of another client.

4.4 Client Letter

“Dear (unit manager)

I am taking this opportunity, now that I have returned home to write to you and your staff to express my very deep and sincere thanks for the quality of care that I was provided with while I was resident at Waverly.

In the build up to my hip operation my family were greatly concerned about how I would cope not only with the rigours of the operation but also with the post operative recuperation. Both my sons live in Edinburgh and as serving police officers have the difficulty of shifts and uncertain hours to cope with. My youngest son had offered to have me stay with him after the operation but the reality of my position in those first days after surgery genuinely brought me to a position of despair. It was clear that I couldn't manage at home and it would have been an unbearable burden for my son and his young family.

From that position of despair, the Waverly project came as a real godsend. I was initially wary of the scheme but I very quickly realised that the quality of the care from you and your staff, the level of physiotherapy and the general commitment of everyone to build not only my physical strength but also my confidence made this scheme an essential element of my recovery.

I have no doubt that I could not have made the transition from the hospital back to independent living without Waverly. The concept of the scheme, to give older people a level of support that is just enough to bridge convalescence through to independent life is truly wonderful. From feeling so much pain and apprehension I now hope that my new hip will give me a renewed lease of life and I owe a significant part of that success to the professionalism and care of this wonderful border's gem that is the Waverley Residential Home."

4.5 Social Worker Care Manager Feedback (clients name anonymised and therapist's name removed)

"I think you are aware of the above lady who we discussed some weeks ago, the outcome of which was for her to be admitted into Crumhaugh.

Mrs Jones was admitted on the 10.1, and is to be discharged this coming Friday, 30.1. The experience has been very positive, and, the physio has been happy with Mrs Jones progress whilst there.

Prior to admission, Mrs Jones mobility had declined, and this was the area staff were to concentrate on as well as monitoring her overall health of course. Mrs Jones has tried very hard to cooperate with staff, and her mobility though not as good as she was when discharged from Waverley last September, is non the less better than it was pre admission to Crumhaugh. Furthermore, Mrs Jones is motivated to continue mobilising when she returns home on Friday.

Following discussion with the physiotherapist, we feel that regular rehab admission would be beneficial for Mrs Jones, as it is certainly proving positive for her, and hopefully could ultimately avoid a future hospital admission. If this was possible, I would be suggesting another admission to either Waverly, (which Mrs Jones preferred), or Crumhaugh, around May/June, for another couple of weeks."

This 64 year old lady was initially being considered by a care manager for permanent residential placement. Please refer to case study 2 in the Waverley Interim Evaluation Report (appendix 5 pp20&21) for full details. It was identified that due to this lady's complex needs that she would benefit from future intensive rehabilitation possibly two or three times a year in a bed based unit to continue to support her to live at home and to also support her husband in his caring role. Since returning home this lady has received further intensive rehabilitation at Crumhaugh Hospital. At the start of 2009, Crumhaugh Hospital provided some intermediate care beds as part of a bigger redesign of community hospital beds. 'Mrs Jones' stated that although Crumhaugh Hospital was in her local community she preferred the non hospital based facility as it better represented her home environment.

5.0 Processes

5.1 The processes and procedures for admission to Waverley IC unit have been recently reviewed and found to be fit for purpose, as follows:-

5.1.1 Criteria

The IC Team have reported through its usage that the criteria appear to be robust and fair and on the whole have ensured that the appropriate people are admitted to the IC unit. There has been an update to some of the wording eg Single Shared Assessment (SSA) now replaced with Core Adult Assessment Documentation (CAAD). An additional bullet point has been added to ensure that nursing and AHP treatment plans follow the client into the unit to ensure continuity of practice and prevent duplication (appendix 6).

5.1.2 Referral Process

The IC Team has also reported that the referral process map has also been found to reflect the correct pathway for action. Once again, some wording has been updated as above (appendix 7).

There is still a need to develop some actions mentioned within the pathway. For example, there has not been an opportunity as yet for social care assistants to follow clients in to hospital to continue their rehabilitation as appropriate. Such an opportunity would assist in the development of the generic support worker model. There is also an inconsistency in home visit reports being downloaded onto framework which would assist care managers with clients transition back home.

There have been positive opportunities in that the IC team are now starting to develop their skills in telecare. One discharge home has required installation of electric gates. The voluntary sector is now becoming more involved eg providing transport, settling people back home, buying basics eg milk etc to settle people back home.

5.1.3 Discharge Plan and checklist

This is a significant area for development. Referrers, on the whole, have not been completing the discharge plan (appendix 8). Until recently the IC team leads (unit manager and Rapid Response manager) have not insisted that this is completed as part of the admission process. A recent incident highlighted how important this is to prevent any misunderstandings about medication. This process has now been tightened and an admission cannot occur without the full paperwork in place at the point of admission despite pressure from referring agents.

5.1.4 Patient Medicine Arrangements

This process was set up specifically for admission to the IC unit, (appendix 9). A question was raised at the start of the pilot regarding whether the process would potentially result in a waste of medicines. A recent incident where the correct procedure was not followed did result in an over supply of medication however this appears to have been an isolated incident. This highlights the importance of following the correct procedure. This process is due to be reviewed.

5.1.5 Contingency Planning

The contingency plan appears to be working well (appendix 10). At the start of the pilot there was an issue with care managers not ensuring that they were responsible for making alternative arrangements should a placement in the IC unit break down or circumstances change for an individuals return home. Although the contingency plan states specifically the bed management formula, pressures from referrers resulted in an eighth bed being opened to assist with acute discharges. However this proved unmanageable due to staff capacity and this bed has now been removed from the system.

5.1.6 File Audit Tool

As part of the IC unit development, new paperwork and client records had to be designed. As it is not an NHS facility medical records do not follow with the client. Residential care homes traditionally do not have full access to Framework (SW IT client recording system). Both NHS and Social Care & Health staff contribute to the clients files. A new system of file management was therefore designed and the File Audit Tool developed. This tool was devised to ensure that client files are properly completed. This tool has been essential to ensure that task responsibility and completion is adhered to (appendix 11). There has been an issue in completion which has resulted in files not always being complete. This is an area of development for the IC Team. There is a wider issue about what happens with client information once they have left the IC unit.

5.1.7 Data Collection System

This system was developed for the start of the pilot and has proven to be essential in being able to evaluate the IC unit. Without this system the statistical data would not have been collected. It includes the data collection sheet (appendix 12) and a computerised data recording tool. The Pulses Scoring tool outcomes are collated within this system. There are no changes required to this system.

5.1.8 Multi-disciplinary Team Meeting Action Plan

This was developed to ensure that tasks are completed for individual clients and reduce any confusion as to who should be doing what, (appendix 13). There are no changes required.

5.1.9 Intermediate Care Service Leaflet

The leaflet has proven to be an excellent tool to ensure that clients understand the meaning of intermediate care and intensive rehabilitation. The leaflet was originally designed for Waverley IC unit however it was amended this year so that it could also be used to support the development of intermediate care beds in the community hospital. The leaflet is now a broad leaflet that can be used in any intermediate care service (appendix 14). This leaflet is due to be reviewed by the Rehabilitation Group in the near future.

- 5.2** It should be noted that the processes described above could be transferred in to other residential care homes should the opportunity arise to further develop intermediate care facilities in such settings.

6.0 Professional Learning and Development

- 6.1** The development of the Waverley IC unit has presented challenges and opportunities for both Rapid Response and Waverley residential care staff. The following sections of this report highlight areas of professional learning and development which has resulted in positive outcomes for both services as a whole and will continue to develop the IC service in the future.

6.2 What works well

6.2.1 IC Team

- √ Very good joint working
- √ Ability to identify clients needs at a more intense level
- √ Sharing of skills eg RR providing orthopaedic training to Social Care Assistants/Workers
 - √ Consolidation of practice out with the unit eg RR transferring skills for IC into the community/wider team
- √ RR more willing to consider more complex cases
- √ Increased enthusiasm for intermediate care
- √ Social care staff have found daily plan of activities helpful
 - √ Dedicated staff have been a great benefit eg social care staff specifically for the IC unit
 - √ End product very important to social care staff – sense of achievement – enabling rather than caring role

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-
- √ RR have transferred experience and skills to community hospital beds

6.2.2 Outcomes for clients

- √ Individualised practice sessions to inform treatment plan
- √ Ability to return/aim for home
- √ Space and time to recover eg 101 year old client
- √ Increased care packages
- √ Collective of knowledge and increased skill base
- √ Improved sense of self worth and confidence to return home
 - √ Continuity of rehabilitation throughout process and delivered by non professional staff and sense of fun
 - √ Removes 'quicker and easier' and 'caring for' mentality
 - √ Provides 24 hour picture of individuals needs – tailored to care plan
 - √ Allows full assessment of need – comprehensive holistic approach to assessment eg dentist, speech and language therapist, podiatry
 - √ More homely environment, non institutional – more 'on your way home' Client's comments when comparing with IC experience in community hospital. Don't feel 'ill' or creating dependency
 - √ Alternative approach to managing needs and more appropriate
 - √ Families heavily involved in plan and have on site support with social work background – doesn't require separate social work referral
 - √ Supports families and carers although not primarily respite
 - √ Able to adapt bedrooms to replicate home
 - √ Clients can continue with normal activities whilst admitted eg going for coffee, bingo, day centre – link with community and returning home remains
 - √ Practice going shopping and preparing meals
 - √ Home visits – identify and reduce risks

6.2.3 Negatives

- No shower
- If inappropriate referral and placement not successful this impacts on client, unit and staff
- Lack of clarity as to concept of what intermediate care is – needs wider marketing
- RR has to pick up care management for people with complex needs and continue long term as localities cannot allocate to social worker

6.2.4 What does not work well

- Completion of paperwork by referrers
- No access to Framework for IC team
- Paperwork to follow client file (NHS) and scan for Framework (SBC)

-
-
- Discharge plan not being sent to IC unit by referrer
 - RR staff changing paperwork too often eg treatment plan and not allowing to bed in
 - Need for consistency of completion of paperwork in IC unit – audit has highlighted this
 - RR staff travelling from outlying areas to cover IC unit – impact on travel, creates pressure elsewhere, lack of consistency/follow up/need to catch up
 - Lack of dedicated Senior social care staff – impact on Manager’s time and other senior staff – follow up work, phone calls in evening by relatives, visitors, paperwork
 - Lack of dedicated RR staff
 - Time commitment to identify appropriate referrals
 - Impact on RR Team Leaders operational and management time
 - Need to expand on Telecare agenda

6.2.5 Areas currently under development within Waverley IC Unit

The points below are currently under development following the evaluation process. It is anticipated that a dedicated Occupational Therapist, Physiotherapist and Senior Social Care Worker will shortly be in place which will resolve many of the issues identified.

Social care staff

- ❖ Support workers widening their role and working across traditional boundaries eg following client home, into hospital should they be readmitted and to ensure continuity of rehabilitation as appropriate.
- ❖ More involvement in home visits in preparation for discharge from Waverley IC unit
- ❖ Continue to update training periodically

Professional Staff

- ❖ Completion of all relevant paperwork
- ❖ Home visit reports completed within timescale and uploaded on Framework. Copy held in file
- ❖ Quarterly pulses scoring completed by appropriate professional within timescale
- ❖ Pulses scoring at point of admission and discharge
- ❖ Exploring of basket of scoring tools. This will connect with other departmental developments eg SW Occupational Therapist role shift in emphasis to provision of rehab. Also links with NHS Occupational Therapy assessment and provides opportunities to develop across services
- ❖ Increased Occupational Therapy input into kitchen tasks, shopping, leisure activities
- ❖ Opportunities for Continued Professional Development (CPD) to expand knowledge, skills and experience in defined areas

-
-
- ❖ Dedicated Senior Social Care Worker, Occupational Therapist and Physiotherapist for IC unit

Paperwork

- ❖ Full completion of paperwork and sign of against audit tool
- ❖ Signing of audit tool by relevant staff
 - ❖ Redesign the treatment programme to utilise across hospitals, community teams
 - ❖ Discharge plan completed before admission and updated weekly at multidisciplinary team meeting (MDT)
- ❖ Paperwork can now be emailed to IC computer for admission
- ❖ Completion of MDT form and follow up on action points
 - ❖ Questionnaires to be handed out to clients at point of discharge for completion and return by post. Client should not be assisted by IC staff
 - ❖ Pulses, data collection sheets to be completed upon discharge and forwarded to identified administrative personnel at SBC HQ. Copy to be held in file

Medication

- ❖ Further develop the self medication process through the use of the medication policy

Other Issues

- ❖ Access to Framework for Occupational Therapist, Physiotherapist and Senior Care Workers in Waverley
- ❖ Framework training for staff
- ❖ Increase involvement of Red Cross and other voluntary sector
- ❖ Access to physiotherapy tools
- ❖ Redevelopment of the bathroom to provide level access shower
- ❖ Decrease length of stay for clients as IC staff skills develop

7.0 Costs and efficiencies

- 7.1 Appendix 4 shows the running cost of the IC Unit at £350,526 and a loss of income of £78,599 giving a total cost of £429,125 per annum. The running cost includes nearly £45,000 for occupational and physiotherapy and Rapid Response management time. This would not normally be factored in to the running costs of a residential care home. Over the 10 month evaluation period, 6 clients were prevented from a permanent admission to a residential care home placement. The average length of stay in a Scottish Borders Care home is 22 months. This equates to a saving of £55,392 per person giving a total saving of £338,349 over that period. Annually this adjusts to £184,554 Table 2. If a minimum of 6

people are prevented from a permanent care home admission every year this would have an accumulated impact on efficiencies for residential care homes over the coming years, Table 3. Please note that this figure has been calculated on an average between internal and external residential care costs.

Scottish Borders Council - Social Work Services

| | |
|----------------------------------------------------------------------------------------|----------|
| Cost per week in-house residential | £591.52 |
| Average Net Cost per week | £591.52 |
| Average Net Cost per 4 wk period | £2,563 |
| Average Net Cost for 22 mth period | £56,392 |
| Efficiencies to SBC from preventing 6 People from care home admission in 22 mth period | £338,349 |

Assumptions

No homecare calculations in efficiencies
 Average length of stay in SBC In-house residential care is 22 months

Gross Efficiencies over 12 month period

| | |
|----------------------------------------------------------------------------------------|----------|
| Cost per week in-house residential | £591.52 |
| Average Gross Cost per 4 wk period | £2,563 |
| Average Net Cost for 12 mth period | £30,759 |
| | |
| Efficiencies to SBC from preventing 6 People from care home admission in 12 mth period | £184,554 |

Table 2

Scottish Borders Council - Social Work Services

Gross Efficiencies to Scottish Borders Council resulting from prevention of permanent admissions to SBC Residential Care Home

Ave Monthly Gross Cost of Residential Care 2288.823

| | Year 1 | Year 2 | Year 3 | Year 4 | | Total |
|--------------------------------------|---------|----------|----------|----------|--|----------|
| No of Mths Saved of Residential Care | 42 | 112 | 132 | 132 | | 418 |
| Total Cost of Efficiencies | £96,131 | £256,348 | £302,125 | £302,125 | | £956,729 |

Table 3

7.2 The evaluation data collection process identified the actual care package individual clients already had pre admission to the IC Unit and what was required post discharge from the IC Unit. It did not identify what clients care packages would have been when discharged directly home from hospital following a period of hospital admission. Given that an individual will most likely have been admitted to hospital following an acute episode or exacerbation of their condition, it can be assumed that they would

require an increase in their care package or a new care package to return home or continue staying at home.

7.2.1 On the basis of the information from the Pulses figures, section 3.1 of this report, it can be assumed that clients returning home direct from hospital will require on average a minimum care package of two hours per week. A care package of two hours per week would cost £32-58. This is calculated on an average hourly rate of £16-29 which is the average hourly cost between internal and external home care providers. Based on the 36 clients discharged home from the IC unit during the 10 month evaluation period, refer to section 2.7 of this report – annually adjusted to 44 clients, this would equate to a total annual cost of £74,543 in addition to the cost of any existing care packages and the cost of any hospital admission.

7.3 There is no charge to clients who are admitted to the IC Unit. It is free at the point of delivery. Any decision to charge clients for this service may result in an increase in admission to hospital or longer length of stays. However it is clear from client feedback that they value the IC unit and the impact on their confidence and safety to return home has lasting effects. This in the longer term will prevent or reduce clients having to rely on service provision. This ‘hidden cost’ is not quantifiable.

7.4 Based on the figures above, the provision of the IC service within Waverley is not quite cost neutral. However it does not take in to account that over the past 10 months there has been no financial contribution from NHS Borders other than a share of Rapid Response resources which is a joint financed team. Future joint funding of intermediate care services would have a significant impact on future savings and efficiencies.

8.0 Opportunities for Wider Development of this Model

8.1 The overall principles and philosophy of this pilot is to support older residents of the Scottish Borders to live in their own homes as long as possible. It aims to prevent unnecessary admission to hospital, facilitate hospital discharge and prevent premature admission to residential care. The pilot so far has achieved one or more of these aims.

8.2 Between 26th May 2008 and 31st March 2009, 51 people have been admitted to Waverley IC unit. 11.8% of admissions prevented admission to a permanent residential care home. 25.5% of admissions prevented admission to hospital. 62.7% of admissions facilitated discharge from hospital.

8.3 Waverley IC weekly unit cost has risen over the year, mainly due to the introduction of Single Status, to £983. With a few exceptions the majority or people admitted have been over the age of 65 years.

- 8.4** For the period 07/08, NHS Borders cost per case for inpatient acute services is £2260. The geriatric assessment in patient cost per case is £4518 (appendix 5 p.17).
- 8.5** There are approximately 22,000 older people (65+) living in the Scottish Borders. This decade alone there is expected to be a 27.7% growth in the 65+ population and by 72% by 2031. This equates to nearly a third of the population by 2031.
- 8.6** The Joint Improvement Team state that *“if we carry on doing more of the same.....*
- *A new 50 bed care home will be required every 2 weeks for next 20 years*
 - *A new 250 bed District General Hospital will be required every 2 years for next 20 years*
 - *By 2020 virtually all school leavers will need to be recruited into the care sector”*
- 8.7** A Best Value Review of Scottish Borders Council’s residential care homes concluded that two of the five residential care homes were not fit for purpose and that the remaining three be better used through provision of short term or long term specialist care services. The Accommodation with Care Strategy (part of the TOPS programme) main recommendations includes *“A new role for Council Care Homes”* and its key outcomes include *“reduction in hospital admissions”* and *“increased range of opportunities to enable hospital discharge and rehabilitation”*. This clearly meets with the demands of national drivers as mentioned in the introduction of this report. Waverley IC unit pilot has demonstrated an effective model that can be a transferable framework to deliver intermediate care in other SBC residential care homes.

| SBC owned Residential Care Homes | Distribution of over 65+ population by locality | Minimum Intermediate Care beds currently required per distribution of over 65+ population | Minimum Intermediate Care beds required per distribution of over 65+ population 2018 |
|-----------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Saltgreen (Berwickshire) | 15% | 4 | 5 |
| St Ronans (Tweeddale) | 17% | 4 | 5 |
| Grove (Cheviot) | 19% | 5 | 7 |
| Waverley (Eildon) | 32% | 7 | 9 |
| Deanfield | 17% | 4 | 5 |

The figures in Table 4 are based on the minimum requirements for over 65+ population for 2009 and 2018. They have been calculated proportionally based on the evidence provided through the evaluation that 7 beds in Waverley serves 32% of the 65+ population in that area.

Given the changing demographic needs as illustrated in section 7.5 of this report, there will be a need to increase the IC provision over coming years. In addition, there is also a younger population of adults with physical disability that also require access to intensive rehabilitation. Any future intermediate care development should therefore include this group of individuals.

8.7.1 The Waverley IC pilot has also demonstrated through regular enquiries to the unit a need for general assessment beds which would allow individuals who require 24/48hour assessment/monitoring/review but do not require the facilities of a hospital. For example an individual who presents in their home environment with mild confusion or dizzy spells and the cause is unclear but may be due to not taking medication and there is a requirement for 24 hour observation. This would help develop a precise care plan to meet that individuals needs. It could also provide an opportunity to practice telecare solutions for safe return home. Clearly this potentially overlaps with services provided by the Community Hospitals including the introduction of intermediate care beds into the Community Hospitals in January this year. NHS Borders Integrated Health Strategy has a focus on better use of buildings and facilities. This raises a question as to whether there is an opportunity to joint fund resources and make better use of buildings to provide for IC and general assessment beds for those services not requiring hospital services.

8.7.2 Waverley IC pilot has also found that an individual's admission for intensive rehabilitation has provided informal carers with a period of respite, allowing them to recharge their batteries. This has been a valuable dual role. If more residential beds could be made available the service could be further developed to provide respite for carers and a period of 'topping up' of skills for the individual. This would have a longer term impact as the individual returning home will be more capable thus further relieving stress on the carer and increasing their ability to continue to care. Individuals self esteem, confidence and functional ability will be increase further improving quality of life.

9.0 Recommendations specific to Waverley IC Unit

9.1 Waverley IC unit has evidenced positive outcomes for service users and has highlighted that this is a valued service. Scottish Borders Council has therefore agreed to continue to fund this project for another year. The pilot has also evidenced that NHS Borders has gained significantly, refer to

point 7.2 of this report, through this pilot. There, therefore needs to be a firm commitment from NHS Borders to jointly supporting the future funding of this service.

Key Recommendation 1:

Joint funding agreement between SBC and NHS Borders to fund Waverley IC unit based proportionally on percentage of prevention of admission to hospital and facilitated hospital discharges thus ensuring a whole systems approach.

- 9.2** Waverley IC unit has developed and continues to develop processes that are clearly beneficial to service users and to the organisations, refer to sections 5 and 6 of this report. There are clear opportunities to use these tools and skills across both NHS and SBC services to provide continuity and a seamless approach to service delivery.

Key Recommendation 2:

Agreement by both NHS Borders and SBC to develop joint enablement tools and processes for rehabilitation which will benefit individuals moving across the services eg one treatment plan which follows the client.

- 9.3 Key Recommendation 3:**

Redesign of Waverley IC unit bathroom to provide level access shower and mainstream bath.

- 9.4 Key Recommendation 4:**

Marketing programme for Waverley Intermediate Care Unit including definitions for IC and rehabilitation, process for referral and importance of discharge plan. This should also include access to information available on both SBC and NHS Borders intranet systems. Use of digital stories should be used to highlight outcomes for clients.

- 9.5 Key Recommendation 6:**

Increase use of Telehealthcare equipment to support people to return home.

- 9.6 Key Recommendation 7:**

Review and further development of medication procedure

- 9.7 Key Recommendation 8:**

Review of client leaflet

- 9.8 Key Recommendation 9:**

Development of quick glance flowchart for teams/services/wards to remind of process for admission to Waverley IC unit.

9.9 Key Recommendation 10:

Further development of Social Care Assistant/Worker role to include working across traditional boundaries, involvement in home visits, update on training.

9.10 Key Recommendation 11:

Development of policy for forwarding on of client information post discharge from IC unit.

9.11 Key Recommendation 12:

Ensure that section 6.25 of this report 'Areas currently under development within IC Unit' are carried through.

10.0 Wider Intermediate Care Recommendations

10.1 The qualitative data collected from the client questionnaires has evidenced positive outcomes for clients. The consistent message for clients returning home is that they need to feel confident and safe. In all the questionnaire returns clients stated clearly that they increased their confidence and felt safe to return home thus increasing their independence in their own environment.

Key Recommendation 13:

Increasing people's confidence and safety within their own home should become an evidenced based outcome to be developed across services and organisations.

10.2 Key Recommendation 14:

Development of intermediate care beds in each SBC residential care home to meet the growing demands of the population in response to demographic changes.

10.3 Key Recommendation 15:

Development of general assessment beds within each SBC residential intermediate care unit.

10.4 Key Recommendation 16:

Development of short breaks/respite beds within each SBC residential intermediate care unit which will provide 'topping up' rehabilitation skills.

10.5 Key Recommendation 17:

Future IC developments to include provision for the younger adults with physical disability population.

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Development of joint discharge protocols across the organisations to ensure that a Discharge Plan is completed at the start of any admission to a service

10.7 Key Recommendation 19:

Development of a protocol that people should not be considered for permanent residential care home placement without first having a placement in an IC unit.

10.8 It is clear from the Waverley IC pilot and from national drivers that people wish to remain living in their own homes. There are periods in people's lives when they are unable to do this safely and confidently. They are therefore admitted into hospital or into permanent residential care environments. This pilot has found that their pathways and transitions are often uncoordinated, poorly planned and result in delays in returning home often dependant long term on provision of services. There is a frustration by front line practitioners at the lack of a seamless service. Although the pilot has demonstrated the effectiveness of an in reach/out reach model across Waverley IC unit, a person's home and at times the hospital environment, it is clear that this could be developed further by the provision of a wider Intermediate Care Service model that will work across the services and organisations following the individual rather than the requirements of the service. The IC service will strive to support the person in their own home however should they require additional supports out with their own environment the IC service team member will follow the person in and follow them back home again. This will truly provide continuity for the person and a seamless pathway of enablement.

10.8.1 Key national drivers are indicated within the introduction of this report. The pilot model demonstrates delivery of many of the key messages.

- Whole systems approach to rehabilitation services
- Shift to inter-agency redesign
- Rehabilitation at the heart of service delivery
- Greater priority to rehabilitation
- Supporting people to live at home
- Provide intensive rehabilitation prior to returning home
- Seamless transition from hospital to home

-
-
- Early intervention, prevention of hospital and care home admissions, facilitating early discharge, rehabilitation and enabling

10.8.2 In addition this model has assisted the organisations towards their targets eg HEAT, Talking Points (formerly UDSET), Community Care Outcomes, Single Outcome Agreement, High Impact Changes and national implementation plans.

Key Recommendation 20:

Development of a joint Intermediate Care Service working across SBC, NHS Borders and the voluntary sector.

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Intermediate Care & Rehabilitation Project

Waverley Intermediate Care Pilot

Key Recommendations

from

Final Evaluation Report

April 2009

Angie Lloyd-Jones
Project Manager

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Intermediate Care & Rehabilitation Project

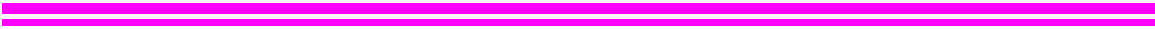
Waverley Intermediate Care Pilot

Final Evaluation Report

Appendices

April 2009

**Angie Lloyd-Jones
Project Manager**



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| Appendix 2 | Case Study 1 |
| Appendix 3 | Case Study 2 |
| Appendix 4 | Cost of Intermediate Care Unit |
| Appendix 5 | IC & Rehabilitation Evaluation Interim Report |
| Appendix 6 | Criteria |
| Appendix 7 | Referral process map |
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Title: Review of Intermediate Care and Rehabilitation Services

1. Purpose

To inform the Clinical Executive of the intended Care Home proposal initiated by Scottish Borders Council's Best Value Review.

2. Background

The shared principles of Changing Lives and Delivering for Health direct a shift in the way that services are delivered, with a greater emphasis on self care and independent living.

The reports identify the need for change in the ways that services are delivered, with shifts to inter-agency service redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling.

Definitions:

Intermediate Care: "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 discharge and prevent premature admission to residential care." (Making Connections, Change Agent Team, 2006)

Rehabilitation: "A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients and service users, and their family carers." (Kings Fund 1998)

Intermediate Care in Scotland A Partnership Approach is a scoping report produced by the Joint Improvement Team (JIT) in June 2007. It states that

"an increasing number of intermediate care projects are being developed by partnerships in Scotland...whilst there is no specific national strategy or guidelines for intermediate care in Scotland, recent policy is directing the development of services to support people as far as possible in their own communities in the context of a whole system approach."

The JIT report also states that

"The success and effectiveness of Intermediate Care services depends upon the range of existing services, including social work services, the extended primary care team and the role of acute and community hospitals. Where services report their greatest successes, it is where the interface between intermediate care services and other hospital or community services are well managed."

3. Current Position

At a local level, Scottish Borders Council is carrying out a Best Value Review within the Social Care and Health department. A work stream within this review is the Review of Intermediate Care and Rehabilitation Services. NHS

Borders is also currently reviewing the role and purpose of the Community Hospitals and Day Hospitals and is developing a strategy for Long Term Conditions.

The Intermediate Care and Rehabilitation Project Group (Appendix A) are currently carrying out a process mapping exercise to better understand the current customer journey as they travel through/across NHS and Social Care and Health services, to identify what works well, gaps, duplication and best use of existing resources.

It has already been established within Social Care and Health that there is a need to look at how SBC residential care home facilities are currently being utilised and their future purpose.

There have been various discussions between Elaine Torrance, Ralph Roberts and Jackie Morten to take forward the proposal laid out below.

Proposal

To carry out a twelve month pilot in which existing local authority residential care homes facilities can provide a resource to deliver Intermediate Care and Rehabilitation services. The aim will be to provide customers with a resource that will promote early supported discharge from hospital and an opportunity to maximise their independent living skills before returning to their own homes.

Resources:

Initially there were two care home resources under consideration for the pilot. This has since been narrowed down to one. It has been agreed that Waverley care home in Galashiels is to be the pilot site due to its central location and accommodation layout. Waverley resource is designed around 'accommodation wings' which provide adequate room space and additional facilities.

It is anticipated that one half time OT and Physiotherapist will be required to provide and oversee the rehabilitation programmes. During the pilot phase Rapid Response resources could be utilised given their level of experience. This would also assist in keeping costs down.

Two care home employees covering a fourteen hour period 8am -10pm, will also be required. There will be a training requirement for the care home employees to increase their skills to be able to deliver the rehabilitation programmes. It will be essential to incorporate the rehabilitation programme into every aspect of the customer's daily living activities to ensure maximum opportunity to increase their independence skills.

There is also an opportunity to consider whether the pilot could be extended to include a Community Hospital resource to provide Intermediate Care provision. This may support some of the work being carried out through the Community Hospitals and Day Hospitals Review.

Criteria:

A 'Criteria for Intermediate Care' would need to be developed to identify the appropriate recipients. The JIT report states that "the majority of Intermediate Care services will only accept patients/clients who are suitable for rehabilitation (ie medically able and motivated)". In some areas only those people over the age of 65 are eligible for services.

Each customer will require a functional assessment and treatment goals that will provide the basis for their rehabilitation programme.

Implications:

- revenue loss for beds
- management of allocations/vacancies
- freeing up of bed space in existing wing
- reduced numbers of beds available for care home placement
- suitability of existing buildings
- roll of Community Hospitals, interface with Rapid Response and Community Health Teams
- charging – is there a cost to the customer?
- to home care employees – may be required to maintain rehab programme once the customer has returned home – training issue?

Benefits/Outcomes:

- Prevent unnecessary hospital admissions
- Enable people to stay in their own homes
- Provide opportunities for intensive rehabilitation
- To reduce admission to residential/nursing home care
- Facilitates hospital discharge thus preventing delays
- Maximise functional ability and independence
- Decrease care packages
- Faster access to some services
- Shift in care from acute to community settings
- Supports national drivers
- Promotes whole system approach to care

Evaluation:

The JIT report highlights that there have been no long term studies of the impact of Intermediate Care services. Although information has been collated by some services, it concentrates on aspects of the service related to care provided within the service however it does not demonstrate how these services impact on the costs of long term independent support services and care.

The JIT report states that it would be valuable to collect more detailed information about increasing or maintaining independence at home and how this impacts upon the carer of an individual eg levels of carer support

required, satisfaction with the service and extent of involvement in increasing/maintaining independence.

Consideration should therefore be made as to what aspects of this service should be evaluated, how this should be done and at what stages, so that an appropriate tool can be designed.

Local evaluation would be used to gather data on effectiveness of service on outcomes for customers, informing costs for the future development of the service, shared IT for both organisations, future use of resources across the organisations and seeking feedback from key stakeholders.

Costs:

Option 1

- | | |
|----------------------------------------------------------------|-----------------|
| • One half time OT and one half time Physiotherapist | £ 41,885 |
| • Two additional social care assistants covering 14 hour shift | £ 92,972 |
| • Revenue costs for loss of beds (Appendix B) | £ 65,965 |
| Total Cost | £202,822 |

Option 2

- Half time OT and Physiotherapist provided by Rapid Response Service. Cost effective to the pilot but loss of hours to Rapid Response. This option would provide an opportunity to explore the future needs of the service and how this dovetails with future developments for Rehabilitation across the services.

NHS Borders Hospital Costs (Appendix C - source SHOW website)

- | | |
|---------------------------------------------------------------|------------------|
| • Geriatric Continuing Care Services Cost per In patient Week | £ 1294.00 |
| • Acute Service Inpatients Cost per Case | £ 2044.00 |
| • Geriatric Assessment Services Cost per Case | £ 4886.00 |

As at the 23/11/07 Delayed Discharge figure for that week was 23.

- $23 \times £1294 = \mathbf{£29,762.00}$, a yearly cost of **£1,547,624.00**

If 15 patients could be moved into Intermediate Care resource this would save the NHS **£1,009,320 per year**. If 6 patients could be moved into an Intermediate Care resource this would save the NHS **£403,728 per year**.

There is a role for the Intermediate Care resource to provide a step up approach to prevent acute admission to hospital. This would demonstrate a saving to NHS Borders of £2044.00 per case.

Next Steps

Project Board/JCT to

- agree proposal and responsibility for costs
- consider interface with community hospitals and day hospitals review and possibility of expanding the pilot to include a Community Hospital resource

- consider interface with Long Term Conditions strategy
- agree basis for criteria
- consider interface with Rapid Response and Community Health Teams
- agree basis for evaluation tool
- recommend that there will be no cost to the customer in receipt of this service

4. **Summary**

Recent national drivers are encouraging partnership organisations to deliver services using a whole system approach with shifts to inter-agency service redesign to ensure that services best meet the needs of their customers. Intermediate Care resources provide a whole system approach to early intervention, prevention, rehabilitation and enabling. SBC has identified through their Best Value Review an opportunity to provide an Intermediate Care resource within an existing care home to provide customers with a resource that will promote early hospital discharge, prevent hospital admission and an opportunity to maximise individuals living skills to allow them to live in their own homes.

5. **Recommendations**

Scottish Borders Council has provided the resources to take this proposal forward. This includes the redesign of an existing building and costs for additional staff. Additional resources have been identified through Delayed Discharge monies which Elaine Torrance will be taking to the Delayed Discharge Steering Group in the near future. The proposal has also been discussed jointly at Senior Management level and it was agreed that the favoured option is to provide AHP services via Rapid Response for the duration of the pilot. This will inevitably place additional pressures on the Rapid Response service.

The Clinical Executive is therefore asked to consider ways to alleviate the pressures on Rapid Response and consider opportunities from this proposal for the future.

The Clinical Executive is also asked to consider the linkages of this proposal with the wider strategic direction eg Long Term Conditions, Community Hospitals review, Rehabilitation Framework.

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Angie Lloyd-Jones
Project Manager
Intermediate Care & Rehabilitation Review
Best Value Review

Angie Lloyd-Jones Project Manager Waverley Intermediate Care Unit Final Report Appendices

Scottish Borders Council
01450-374545
25-02-08

(Appendix A)

Review of Intermediate Care & Rehabilitation Services Project Structure

Project Co-ordinator: **Angie Lloyd-Jones**

Role:

- To facilitate and co-ordinate the various work programmes that fall under the Intermediate Care and Rehabilitation agenda.
- To monitor and evaluate the project progress against agreed Project Objectives set in Project Brief.
- To report to the Intermediate Care and Rehabilitation steering group/Executive Group.
- Consult with BVCCF / disability user representation group.

Project Directors: **SBC & NHS**

Role:

- To offer guidance and support on overall direction of the project.
- To ensure that the project work programmes follows national and local strategic direction.
- To direct decision making out with project group capacity.

Project Group:

| | | |
|--------------------------|-----------------------------------------------|------------------------|
| Heather Maughan | Director of Nursing/Project Chair | NHS Borders |
| Angie Lloyd-Jones | Project Manager | SBC |
| Margaret Purves | Care Home Group Manager | SBC |
| Shona Cavers | Rapid Response | SBC/NHS Borders |
| Linda Stewart | Lead Clinician Physiotherapist | NHS Borders |
| Jane McIver | Discharge Liaison Team | NHS Borders |
| Joyce Fortune | Training & Staff Development | SBC |
| Linda Jackson | Joint Future Implementation Officer | SBC |
| Annette Fleming | Acting Home Care Service Manager | SBC |
| Lynne Huckerby | Unscheduled Care Network Manager | NHS Borders |
| Jane Douglas | Group Manager Care Management & Ax | SBC |

Role:

- To facilitate, support, lead and action identified work programmes as appropriate to each individual service.
- To support and report progress to the Project co-ordinator.
- To meet on a bi-monthly basis to update on progress of work programmes.

(Appendix B)

| | <u>Average income per bed 2007/08</u> | <u>Number of Beds Being Removed</u> | | <u>Loss Of income Per week</u> | <u>Loss Of income Per Year</u> |
|----------|---------------------------------------------------|-------------------------------------------------|---|--------------------------------|----------------------------------------|
| Waverley | £ 158.57 | 8 | £ | 1268.56 | £ 65965.12 |

** Could be some assumed slippage but the income will also be higher next year due to inflation so this is just a guide.*

(Appendix C)

R360: PROVISION OF HEALTH CARE - GERIATRIC CONTINUING CARE SERVICES

April 2006 - March 2007

Number of Boards: 13

| Board | Inpatients | | | Day Patients | | | Total | Per |
|-------------------------------|---------------------|--------------------|---------------------------------------|---------------------|-------------|--------------------------------|---------------------|------------------|
| | Expenditure £000 | Inpatient Weeks | Cost per Inpatient Week £ | Expenditure £000 | Attendances | Cost per Attendance £ | Expenditure £000 | o Sco Expe |
| Totals or Averages | 138,046 | 103,019 | 1,340 | 287 | 663 | 433 | 138,333 | |
| NHS Ayrshire & Arran A | 11,782 | 8,494 | 1,387 | - | - | - | 11,782 | |
| NHS Borders B | 3,382 | 2,613 | 1,294 | - | - | - | 3,382 | |
| NHS Fife F | 18,597 | 10,690 | 1,740 | - | - | - | 18,597 | |
| NHS Greater Glasgow & Clyde G | 15,205 | 14,438 | 1,053 | - | - | - | 15,205 | |
| NHS Highland H | 7,557 | 4,652 | 1,624 | 58 | 464 | 125 | 7,615 | |
| NHS Lanarkshire L | 17,345 | 14,380 | 1,206 | - | - | - | 17,345 | |
| NHS Grampian N | 9,888 | 6,794 | 1,455 | - | - | - | 9,888 | |
| NHS Orkney R | 1,472 | 474 | 3,108 | - | - | - | 1,472 | |
| NHS Lothian S | 19,739 | 17,983 | 1,098 | - | - | - | 19,739 | |
| NHS Tayside T | 11,156 | 7,219 | 1,545 | - | - | - | 11,156 | |
| NHS Forth Valley V | 10,622 | 9,609 | 1,105 | - | - | - | 10,622 | |
| NHS Dumfries & Galloway Y | 8,634 | 4,100 | 2,106 | - | - | - | 8,634 | |
| NHS Shetland Z | 2,667 | 1,574 | 1,694 | 229 | 199 | 1,150 | 2,896 | |

R310: PROVISION OF HEALTH CARE - ACUTE SERVICES

April 2006 - March 2007

Number of Boards: 15

| Board | Inpatients | | Cases | Cost per Case £ |
|-----------------------------|-------------|------------------|----------------|--------------------------|
| | Expenditure | £000 | | |
| Totals or Averages | | 1,966,474 | 828,071 | 2,375 |
| NHS Ayrshire & Arran | A | 125,331 | 58,719 | 2,134 |
| NHS Borders | B | 36,256 | 17,736 | 2,044 |
| Golden Jubilee | D | 24,087 | 6,082 | 3,960 |
| NHS Fife | F | 96,393 | 41,714 | 2,311 |
| NHS Greater Glasgow & Clyde | G | 608,675 | 235,501 | 2,585 |
| NHS Highland | H | 105,899 | 45,429 | 2,331 |
| NHS Lanarkshire | L | 148,706 | 78,576 | 1,893 |
| NHS Grampian | N | 216,168 | 83,621 | 2,585 |
| NHS Orkney | R | 6,741 | 2,071 | 3,255 |
| NHS Lothian | S | 286,867 | 127,645 | 2,247 |

| | | | | |
|-------------------------|---|---------|--------|-------|
| NHS Tayside | T | 174,417 | 72,540 | 2,404 |
| NHS Forth Valley | V | 67,247 | 30,737 | 2,188 |
| NHS Western Isles | W | 13,469 | 4,470 | 3,013 |
| NHS Dumfries & Galloway | Y | 49,247 | 20,984 | 2,347 |
| NHS Shetland | Z | 6,969 | 2,246 | 3,103 |

R330: PROVISION OF HEALTH CARE - GERIATRIC ASSESSMENT SERVICES

April 2006 - March 2007

Number of Boards: 12

| Board | Inpatients | | Cases | Cost per Case £ |
|-----------------------------|-------------|----------------|---------------|--------------------|
| | Expenditure | £000 | | |
| Totals or Averages | | 259,132 | 51,954 | 4,988 |
| NHS Ayrshire & Arran | A | 21,416 | 4,076 | 5,254 |
| NHS Borders | B | 3,454 | 707 | 4,886 |
| NHS Fife | F | 8,780 | 2,473 | 3,551 |
| NHS Greater Glasgow & Clyde | G | 74,155 | 14,975 | 4,952 |
| NHS Highland | H | 8,215 | 1,457 | 5,638 |
| NHS Lanarkshire | L | 27,982 | 6,353 | 4,404 |
| NHS Grampian | N | 15,042 | 3,732 | 4,030 |
| NHS Orkney | R | - | - | - |
| NHS Lothian | S | 51,689 | 7,866 | 6,571 |

| | | | | |
|-------------------------|---|--------|-------|-------|
| NHS Tayside | T | 15,412 | 2,678 | 5,755 |
| NHS Forth Valley | V | 28,890 | 6,222 | 4,643 |
| NHS Dumfries & Galloway | Y | 4,097 | 1,415 | 2,895 |

WAVERLEY INTERMEDIATE CARE UNIT CASE STUDY NUMBER 1

Mr X is a 75 year old who lives alone in a ground floor privately owned flat. 6 weeks ago Mr X was carpet bowling with his local club when he slipped and sustained a right fractured neck of femur. He was admitted to hospital where a pin and plate operation was performed.

Prior to the fall Mr X was completely independent with all aspects of daily living and had no home care input. He was extremely active and would typically go for a one mile walk most days.

Having been stabilised medically Mr X was transferred to Waverley Intermediate Care Unit for rehabilitation. Upon arrival Mr X was mobilising with a wheeled walking frame however the expectation was that he would progress to using only sticks.

Assessment within Waverley Intermediate Care Unit (IC Unit) was completed by both occupational and physio therapy and a treatment plan was produced.

There were two areas of need that were addressed by Occupational Therapy. There was a reduced ability to prepare basic snacks and hot drinks as a result of poor mobility and reduced dynamic standing balance. Daily rehabilitation took place within the Intermediate Care kitchen area with the aim being to develop independent function within a four week period. The IC Unit Social Care Assistants/Workers were advised by the occupational therapist about how to deliver the rehabilitation treatment programme and were provided with the correct equipment with which to assist Mr X. For example the correct height and positioning of perching stools and kitchen trolleys were demonstrated. Due to a reduced range of movement in his right hip Mr X required the assistance of one person to dress lower half garments. Daily dressing practice took place with the aim being to achieve independence with the aid of equipment over a four week period. Dressing equipment was supplied to the client and the Social Care Assistants/Workers were shown the techniques that the client would need to develop.

There was one need identified by physiotherapy. The client was experiencing an extreme reduction in mobility level, caused by muscle weakness following the fractured neck of femur. The aim of treatment was to sufficiently improve mobility so that Mr X could return home, ideally going from walking frame to two sticks. A twice daily exercise programme was set up and implementation of this was explained to the Social Care Assistants/Workers. For example they were shown specific exercises and advised when to prompt the client and when to provide hands on support.

Mr X achieved the desired outcome within the time scales that were set. Following a final home visit to ensure that the environment was set up appropriately he was discharged home.

Mr X had a Pulse score of 18 upon admission, 13 on discharge and 12 at follow up review.

WAVERLEY INTERMEDIATE CARE CASE STUDY NUMBER 2

Mrs Z is a 75 year old who lives alone in a third floor housing association one bedroom flat. Approximately 8 weeks ago Mrs Z was discharged from hospital following a sub dural haematoma. 6 weeks were spent at home before re-admission to hospital as a result of reportedly not coping at home. Referral to Waverley Intermediate Care Unit (IC Unit) from hospital therefore followed as it became clear that medically and physically she was functioning well but it was felt that psychologically she was not coping.

Occupational therapy assessment within Waverley identified that the six weeks at home post discharge from hospital had effectively been spent housebound due to reduced confidence towards going out. Prior to the sub dural haematoma Mrs Z had been completely independent with all aspects of daily living and socially integrated well in the surrounding community.

A treatment plan was devised that would focus upon increasing Mrs Z's confidence. The aim of treatment was to use a graded re-socialisation programme over a two week period to develop Mrs Z's confidence and therefore successfully reintegrate Mrs Z into her immediate social environment.

By using a client centred approach, activities were identified that had meaning to the client and then guidelines were produced that could be used by the IC Unit Social Care Assistants/Workers to assist with implementation. The guidelines required that the Social Care Assistants/Workers work within a timetable that was agreed with the client. Additionally, examples were given to the staff of the type of psychological support and encouragement that should be given to the client whilst out in the community.

Over the two week period staff gradually withdrew their support and increasingly placed demands and expectations upon Mrs Z.

Mrs Z achieved the desired outcomes within the timescale set and was discharged back to her own home after three weeks within the IC Unit. The decision was taken to refer the client to Rapid Response upon discharge from the IC Unit. The reason for this referral was to monitor the situation for a further 6 week period to ensure that successful psychological adaptation took place. This further input from Rapid Response was successful to such an extent that the client has now returned to the previous part time employment that she had pre injury. Mrs Z has stated that she now feels " like a different women".

Pulse score was 9 upon admission and 6 upon discharge. A review of Pulse scoring shall follow in due course.

Scottish Borders Council
Cost of Intermediate Care Unit at Waverley RHOP

No of Wings
in Waverley
5

| Description | Annual Total (£) |
|---------------------------------------------------------------|-----------------------------|
| <u>Staff Costs:</u> | |
| 1/5 Management Time Grade 9a | 8,097 |
| 7.95 fte x Social Care Assistant Grade 4d (plus cover) | 213,210 |
| 1/5 Night Staff (Social Care Worker) Grade 5d (plus cover) | 14,244 |
| 1/5 Night Staff (Social Care Assistant) Grade 4d (plus cover) | 12,568 |
| 1/5 Clerical Time Grade 4a | 1,861 |
| Manager (Rapid Reponse) Band 7 | 6,369 |
| 0.5 fte Physio (Rapid Response) Band 6 | 18,052 |
| 0.5 fte OT/Care Manager (Rapid Response) Grade 9a | 20,242 |
| 1/5 Manual Workers (Kitchen Staff) incl cover | 11,401 |
| Sleep-ins | 4,419 |
| Employee Insurances | 316 |
| Group Life Assurance | 187 |
| <i>Sub-Total</i> | <u>310,966</u> |
| <u>Property Costs:</u> | |
| Handy Manning | 583 |
| Ground Maintenance | 159 |
| Electricity | 2,971 |
| Gas | 4,141 |
| ESWA Charges | 1,826 |
| Cleaning/Cleaning Materials | 1,321 |
| Window Cleaning | 42 |
| Property Insurance | 172 |
| <i>Sub-Total</i> | <u>11,215</u> |
| <u>Transport Expenses:</u> | |
| Vehicle Time Charge | 76 |
| Driver Cost | 100 |
| Vehicle Mileage Charge | 126 |
| Hire of Vehicles & Haulage | 22 |
| Car Allowances (Staff) | 90 |
| <i>Sub-Total</i> | <u>414</u> |
| <u>Supplies & Services:</u> | |
| Purchase of Furniture & Fittings | 569 |
| Maint of Furniture & Fittings | 363 |
| Cost of Food | 6,115 |
| Uniforms & Protect Clothing | 97 |
| Uniforms & Protect Clothing - Glove | 0 |
| Printing/Stationery & Publics | 140 |
| Aids to Daily Living | 485 |
| Aids to Daily Living - Maintenance | 0 |
| Telephones | 0 |
| Telephones Rentals | 213 |

Appendix 4

| | |
|-------------------------------------|----------------|
| Telephones Calls | 0 |
| Other Insurances | 85 |
| Other Supply Expenses | 448 |
| Pest Control | 0 |
| <i>Sub-Total</i> | <u>8,515</u> |
| | |
| <u>Third Party Payments:</u> | |
| Payments to Contractors | 0 |
| Care Commission Fees | 1,373 |
| <i>Sub-Total</i> | <u>1,373</u> |
| | |
| <u>Income:</u> | |
| Non-Resid Staff Meals | -133 |
| Recharge SW Day Care | 0 |
| <i>Sub-Total</i> | <u>-133</u> |
| | |
| Total Direct Costs | <u>332,350</u> |
| | |
| Central Support | 7856 |
| Social Work Overheads | 3970 |
| Asset Rentals | 6350 |
| Total Indirect Costs | <u>18176</u> |
| | |
| Total Costs | 350,526 |
| Assume 98% Occupancy | 357,680 |
| Total Beds | 7 |
| | |
| Unit Cost per week at 98% Occupancy | £983 |

Note:Loss of Income:

Average income per bed 2008/09 (8 beds)

| | |
|--|---------------|
| | <u>-78599</u> |
|--|---------------|

| | |
|--------------|---------------|
| <i>Total</i> | <u>-78599</u> |
|--------------|---------------|



Intermediate Care & Rehabilitation Project

Waverley Intermediate Care Pilot

Interim Evaluation Report

October 2008

**Angie Lloyd-Jones
Project Manager**

Contents

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Acknowledgements

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1.0 Introduction

- 1.1 The shared principles of Changing Lives and Delivering for Health direct a shift in the way that services are delivered, with a greater emphasis on self care and independent living.

The reports identify the need for change in the ways that services are delivered, with shifts to inter-agency service redesign and the need for a whole system approach to early intervention, prevention, rehabilitation and enabling.

- 1.2 *Co-ordinated, Integrated and fit for Purpose: A delivery Framework for Adult Rehabilitation* now places rehabilitation at the core of service redesign.

- 1.3 *Intermediate Care in Scotland A Partnership Approach* is a scoping report produced by the Joint Improvement Team (JIT) in June 2007. It states that

“an increasing number of intermediate care projects are being developed by partnerships in Scotland...whilst there is no specific national strategy or guidelines for intermediate care in Scotland, recent policy is directing the development of services to support people as far as possible in their own communities in the context of a whole system approach.”

The JIT report also states that

“The success and effectiveness of Intermediate Care services depends upon the range of existing services, including social work services, the extended primary care team and the role of acute and community hospitals. Where services report their greatest successes, it is where the interface between intermediate care services and other hospital or community services are well managed.”

- 1.4 Definitions (provided in JIT report):

Intermediate Care: “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 discharge and prevent premature admission to residential care.” (Making Connections, Change Agent Team, 2006)

Rehabilitation: “A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients and service users, and their family carers.” (Kings Fund 1998)

- 1.5** Over the past year, Scottish Borders Council has been carrying out a Best Value Review within the Social Care and Health department. A work stream within this review is the Intermediate Care and Rehabilitation Project. A work stream within this project is the development of an intermediate care resource that will deliver intensive rehabilitation based on the above definitions.
- 1.6** Earlier this year an eight bedded wing of Waverley Residential Care Home was redesigned to provide a seven bed intermediate care resource. This new service was launched on the 26th May 2008 and will run as a twelve month pilot to explore the viability of such a service as a future model of service delivery.
- 1.7** This report is the interim evaluation of the unit and the impact and outcomes of this service for clients, services and organisations. It covers the period between 26th May 2008 and 30th September 2008. Information within this report has been gathered from client feedback questionnaires, key stakeholder questionnaires, validated client dependency rating tool and a locally designed data collection and recording system. Three case studies have been included in the appendices (appendix 1) to illustrate clients that have been admitted to the unit to (1) prevent a hospital admission, (2) prevent a care home admission, (3) facilitate a hospital discharge.

2.0 Statistical Data

2.1 Referrals

From 26th May 2008 to 30th September 2008 there have been 15 admissions, figure 1. Within the first month of opening it was agreed to limit admissions to one per week to allow staff within the unit and who support the unit to adjust to their new role and new processes and procedures. The unit was been full on two occasions. The 85% occupancy rate for bed management has resulted in an effective system for turnover of beds. Referrals tailed off towards the end of August and only one referral was received in September. It is unclear as to why this period was less active however it may be that it mirrors NHS activity levels which show a similar pattern. Since September the referrals have picked up again and the unit is once again under demand.

* Note: referral rates at end of September to end of October resulted in 14 new referrals, resulting in 9 admissions in October. This resulted in an 8th bed being opened temporarily and a waiting list created.

Figure1

2.2 Reason for Referral

Of the 15 referrals, 6 have prevented a hospital admission, 7 facilitated a hospital discharge and 2 prevented an admission to permanent residential care home, figure 2.

Figure 2

2.3 Referrer

Of the 15 referrals, 3 were from BGH, 2 from Community Hospitals, 2 from GPs, 7 from Social Work Teams and 1 direct from A&E, figure 3.

Figure 3

2.4 Diagnosis

The diagnosis is categorised by the main presenting illness, condition or disability at the point of referral. Of the 15 referrals, there was 1 surgical, 1 medical, 3 mobility, 2 neurological and 8 orthopaedic/falls, figure 4.

Figure 4

2.5 Average Dependency Score

The pulses dependency scoring tool is a validated tool which was already being used by the Rapid Response team before the unit opened. It was agreed at the outset of the pilot that this tool would be used for the purposes of the pilot as the staff were already familiar with its use. However it is recognised that any one tool has its limitations and that perhaps a more useful approach to measuring outcomes for individual need would be a 'basket' of tools that can measure more specific needs. It is hoped that this can be explored during the second period of the pilot. Of the 15 admissions, 12 demonstrated a reduction in dependency on discharge, 1 scored the same on discharge as on admission, 2 were still in the unit and had therefore not yet been scored. The average fall in dependency decreased from 13 to 10, figure 5.

Figure 5

2.6 Average length of stay by presenting condition

The average length of stay overall is 29 days. Figure 6 breaks this figure down according to the main presenting condition, disability or illness at the time of admission. It should be noted that the neurological category's above average length of stay is due to the lady that is waiting for a permanent care home placement.

Figure 6

Average length of stay for facilitated discharge was 29.7 days, prevention of admission to care home was 48 days and prevention of admission was 22 days.

2.6 Discharge Outcome

Of the 15 referrals, 13 were discharged to their own home, 1 moved into interim arrangements within a respite facility as he had become homeless and required sheltered accommodation and 1 remained within Waverley (marked unknown) as she was found to be unsafe to return to her own home and was at the time of writing waiting on a permanent place within Waverley residential care home, figure 6. A point to note, for the lady that could not return home, her stay in Waverley and particularly her home visit highlighted the level of risk for this lady and helped her family and the care manager come to the decision that a permanent care home provision was the most suitable alternative for her. Had this lady returned straight home from hospital it is believed that she would have undoubtedly come to harm even with a large care package and required readmission to hospital.

Figure 6

2.7 Average Size of Care Package

The average hours of care package has almost doubled on discharge from the unit, figure 7.

Figure 7

It should be noted that although the care package hours for some people has increased this has supported individual clients to continue to live in their own homes. This supports the following HEAT targets and Single Outcome Agreement:-

T1 : By 2008-09, we will reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient 2 or more times in a single year by 20% compared with 2004/05 and reduce, by 10%, emergency inpatient bed days for people aged 65 and over by 2008.

T8 : Increase the level of older people with complex care needs receiving care at home.

Of the 13 referrals discharged home, 7 had an increase in care package, 5 stayed the same, 1 had a reduction resulting in no support at all. For those clients that stayed the same or had an increase in care, their stay in the unit directed specific areas of targeted care for those individuals. The Intermediate Care team were able to say specifically what that client required and when. For example, one lady presenting with confusion, although not her main diagnosis, did not have a care package pre-admission. On discharge she was assessed as needing 10.5 hours for medication prompts by a home carer. Telehealthcare was not considered suitable at this time due to the individual's level of confusion and practitioners were unfamiliar with what could be provided. This removes the ambiguity that is often found in care packages such as 'requires home care' but not always clear when and for what specific task. One gentleman who fell under the diagnosis of ortho/fall that did not have a care package pre-admission and required 15 hours per week on discharge. His admission to the unit prevented a hospital admission. Given his 'actual length of stay' in the unit was 31 days, this potentially would have cost NHS Borders £5953 for the same duration in hospital. It would have cost £944 home care rate for that same length of time if he had been able to stay in his own home. His length of stay in the unit cost £2879 plus the loss of income cost to SBC of £702 giving a total cost/loss to SBC of £3581 (Table 1 p17).

3.0 Client Questionnaires

3.1 The client questionnaires have provided qualitative feedback on their experience of their stay in Waverley. Fourteen questionnaires have been returned (93% of all admissions). The questionnaires indicated clearly that clients were happy with the service they received in the unit. Clients felt that they achieved the aims of their rehabilitation, improved their ability to carry out activities at home, increased their confidence and felt safer and more able to support themselves at home. Clients also felt that their length of stay was about right. Clients indicated that they found the staff friendly, courteous and efficient and provided encouragement. There were three negative comments regarding the food and several clients suggested that there should be shower facilities. One client complained that there was only one toilet and another complained that there were no en-suite facilities. One client complained that there were no calendars. Comments included:-

3.2 Best thing about my stay:

“Having time to come to terms with what happened and having staff to keep me comfortable. I felt secure that the staff knew what they were doing.”

“Encouragement. I especially appreciated the additional physio support from the team following the physio’s instructions. Very happy with care/support from physio herself, boosting my confidence. A bit of space to recover a bit more before going home and be encouraged that I could make a good recovery.”

“Staff were extremely friendly and efficient. Allowed me to get out of hospital earlier and prepared me for returning home.”

Worst thing about my stay:

“It was not what I required or needed other than the exercises.”

“Nothing”

4.0 Key Stakeholders Questionnaires

- 4.1** Thirty questionnaires were returned. Eleven questionnaires indicated that they had not had involvement with the unit. The main reason cited was that they had not identified a suitable client/patient during the period being evaluated. Nineteen questionnaires indicated that their service had involvement with the unit. Thirteen of those questionnaires had referred clients to the unit and six stated that they provided a service within the unit.
- 4.2** Of the people/services that had referred into the unit, seven responses were from social work (SW) based teams (all but Peebles responded), three were from general practitioners (GPs) (2 Galashiels, 1 Earlston) and three were from Department of Medicine for the Elderly (DME) Consultants. The frequency of referrals was either once or occasionally for all but one referrer. One referrer (Galashiels locality) stated that they had very frequent involvement with the unit.
- 4.3 Of the three GPs that responded**, three stated that there had been minimum impact on their service. One GP stated that there had been an impact on their budget as the client’s own GP had refused to prescribe the medication. Two GPs stated that they were satisfied with the service and one stated that they were very satisfied. All three GPs stated that the admission to the unit had prevented an admission to hospital, prevented a care home admission, facilitated an hospital discharge or a combination of

these. All three GPs stated that there had been positive outcomes for clients. None identified an impact on training, travel, policies or practice.

- 4.4 Of the three DME Consultants that responded**, two stated that there had been minimum impact on their service and one stated that there had been normal impact. One stated that there had been no impact on their budget, and two did not respond to this question.

All three stated that they were satisfied with the service. Two consultants stated that the admission had facilitated a hospital discharge, one of which was an earlier discharge and that there had been positive outcomes for clients.

When asked if there was a role for other members of their service to provide input to the unit, one consultant indicated concerns that patients were admitted/discharged without specialist geriatric review.

The consultants identified no impact on budget, training, travel, policies or practice.

- 4.5 Of the seven SW based teams that responded**, three stated minimum impact on their service, two stated normal impact, and two stated that there had been intensive impact which had resulted in capacity issues for their staff. It is worth noting that these SW teams were from areas which support the BGH and Waverly.

Two teams stated that they were very satisfied with the service; three stated that they were satisfied with the service, and two felt unable to comment as they had not had a client admitted to the unit.

Four teams stated that the admission had facilitated a hospital discharge and prevented a permanent care home admission; one stated that admission to Waverly had prevented a hospital admission. Five stated that there had been positive outcomes for clients, of which two also stated negative outcomes, one of which was not having a care option available to the client who was unsafe to return home. The other team did not indicate why.

Four teams stated that there had been a positive impact on care packages/costs, of which two of the three stated that there were both positive and negative impacts. Three did not comment.

Six teams stated that there had had not been an impact on their budget, with one of those teams stating that it had a positive impact on their budget as the person could return to their original care plan on their return from the unit.

Two teams stated that there was no increase in travel costs, two stated minimal increase, and two identified an increase. There were no training needs identified. Four teams stated that they have not had to change their service policies, procedures, philosophy or model of practice, whilst two teams stated that they had, in as much as the unit helped promote the rehab agenda and helped staff be mindful of the facility.

4.6 Comments from sections of questionnaire:-

“provided a new and safer option for discharge from A&E. Without this service either an emergency care home admission or additional home care would have been required. Waverley provided an opportunity to take an holistic approach which CCA was able to participate in.”

“as a result of direct experience, the team has been in a better position to promote the use with other agencies eg GP practices.”

“very worthwhile pilot, though still need to work on the prevailing culture.”

“not convinced that an old residential care home is the most apposite of premises.”

“altogether a positive experience for Social Worker and client with no gaps identified.”

“enabled client to return home to care of husband who felt more enabled to continue his role as main carer.”

“staff have felt they have had to give a high degree of input both during, and immediately after, a placement by one of our service users.”

“satisfactory in the majority of cases. However there have been a number of cases where we have questioned how much rehabilitation is actually taking place on a daily basis. We have difficulty with the eligibility criteria for the unit – we would have questioned the appropriateness of some placements (but they seemed to suit the unit), whilst access to the service was denied for some service users we thought would benefit.”

“Waverley offers a very valuable resource and one which should be considered first prior to looking at Care Home or more intense package post hospital which may not be successful as service user not confident/fit enough on discharge to take on board all responsibilities both practical and emotional.”

4.7 Six teams/services stated that they provide a service within the unit, as follows:-

Gala District Nurse (DN) Team – stated occasional/frequent involvement. This is in part due to attending the weekly multi-disciplinary team meeting. The impact on the DN service is minimal as patients involved have few nursing needs. One patient from out with Gala practice required intensive input. The impact on travel had decreased as a client was seen within the unit instead of the nurse having to travel to their home.

There has been no impact on budget as access for prescription for dressings has been provided by the client's own practice.

There was no change to policies, procedures, practice noted. There were no training gaps identified. The teams input in the unit was stated as satisfactory although communication not always clear.

An identified gap in the unit was stated as the nurse not always being aware of the client's full care needs. It was stated that premises are suitable as a fair representation of the home environment, and more so than a hospital setting. Admission to the unit facilitated a hospital discharge and resulted in positive outcomes for individuals.

Professional opinion is that individuals who have returned home are more independent and confident.

4.8 Borders Ability Equipment Store – stated occasional involvement with minimum impact. There was a very slight impact on travel and budget. No training needs were identified. They stated that their team's input to the unit as very satisfactory. There were no gaps identified although telecare equipment could have potentially been utilised more. It was also stated that there was a positive impact on costs/care packages.

4.9 Home Care – stated that involvement has been on one occasion and there was a normal impact on the home care service. There was no impact on the service budget. There had been an impact on day to day business due to sickness and annual leave, but there were no changes required to policies and procedures

With regard to training Home Care Service would like to see all home care assistants trained in rehabilitation. The team input to the unit stated as very satisfactory. The feedback stated that the Home Care Service would like to see Home Care Assistants work with service users in the unit and follow them home to continue the rehabilitation work. They also stated that the premises were suitable and that there had been a positive impact on costs/care packages. They felt that admission to the unit has resulted in positive outcomes for service users and this had allowed individuals to stay in their own home longer.

4.10 Rapid Response (RR) – stated that involvement has been very frequent and the impact on their service has been intensive. They are the core team providing rehabilitation to the unit. Eight of the 15 admissions have required a care management role from RR staff. The manager, staff and secretarial support have all had to change the way in which they work. This has had negative and positive impacts on their team.

The RR team have prioritised working within the unit and are working to a rota system to provide cover. This has had a direct impact on their ability to take on RR referrals within their own localities and how they take annual leave due to staff being part-time and the need to cover the unit. Input in the unit initially was intensive. Time spent in Waverley was 97.5 hours in June, 64 hours in July and 33 hours in August. In June Physio input was 22% OT 30%, July Physio 8% OT 30%, August Physio 9.5% OT 7.5%.

RR practitioners that responded stated that they are able to utilise their professional skills has resulted in a more rehabilitation-focused approach across all aspects of their work. This has led to an increased understanding of rehabilitation across health and social work services. It has enhanced their skill base and they are transferring new systems and processes, for example treatment programming, into other aspects of their work. Some practitioners have felt challenged in their practice and this has resulted in the RR Manager spending additional time with staff to work through the issues.

There has been an impact on travel costs as RR practitioners have had to travel from Peebles, Duns and Hawick to cover the rota. There has been an impact on RR response budget as 14K additional budget not enough to provide additional professional staff time. They are however currently employing temporary Community Care Assessor to manage some of the workload.

Training requirements have been identified for RR practitioners. For those RR practitioners that responded they stated they are satisfied in relation to their input into the unit and the RR Manager stated very satisfied.

Gaps identified within the unit are: the bathroom is inadequate for rehabilitation; further equipment is required; and there was some concern with the kitchen although the specific issue was not given. RR practitioners stated that some areas do not wish to promote the unit as it is based in Galashiels. RR practitioners feel there is potential for nurses within RR to be more active within the unit, for example: taking blood pressures, medication, diabetes management, taking bloods. This would lead to potentially increasing the remit of the unit. RR practitioners stated that the premises are suitable however still room for improvement.

RR practitioners stated that there has been a positive and negative impact on care packages/costs. Some clients have required an increase in care following discharge from the unit however this has allowed the client to stay at home. Some clients have required less care. Some clients have required a small package of care however this has been reviewed by RR and removed when assessed as appropriate.

RR practitioners stated that admissions to the unit have prevented hospital and permanent care home admissions and facilitated hospital discharge. Outcomes for individuals have been positive although some more than others and that admission to the unit has resulted in individuals being able to stay in their own homes longer, as evidenced through the Pulses scoring tool and outcomes of discharge destination. Although one lady required a permanent residential care home placement the RR practitioners stated that the process of assessment and home visit greatly helped the family come to an informed decision about future care needs and provided the care manager with detailed information based on information gathered over a 24 hour period. The RR Manager stated that there is also an option to explore whether one or two beds in the unit could be used as assessment beds for people who do not require hospital admission but may be unable to stay at home.

RR practitioners stated that 3 people have been readmitted to hospital following discharge from the unit. One individual who was re-admitted after 24 hours had complex mental health issues and this followed her normal pattern of behaviour. Another individual who was re-admitted three days after admission had another health issue that required hospital care. A further client re-admitted two days after discharge had changed health needs.

- 4.11 Waverley IC staff** – stated that their involvement in the unit has been very frequent and the impact on their service intensive. Staff has had to work in a more rehabilitative/re-enablement way to deliver treatment programmes with individuals. Staff had received training in this area. Senior staff responsibility has increased to manage the unit with frequent admissions and discharges and be involved in regular meetings with key people involved in the project. This will have impacted on senior staff time in the other 4 units. There has been an impact on Waverley's budget of £9004.10 for set up and alterations to the building (appendix 3). There is an additional cost to staff the unit based on an additional two care staff between 08.00 and 22.00 hours (appendix 2).

There has been a minimal impact on the service's day to day business. This has involved the development of multi-disciplinary team meetings, increased joint working, higher turnover of admissions and discharges, and ongoing management and evaluation of the unit. Policies and

procedures have had to change including the introduction of new criteria for admissions to the unit, a brochure for the service, new paperwork and filing systems. Training needs have been identified for staff.

Waverley staff stated that they are very satisfied in relation to their input to the unit. They also stated that the unit is a very suitable environment for the intermediate care service although there needs to be provision of a shower facility.

Waverley staff stated that there has been a positive and negative impact on costs/care packages. The unit provides a free service for several people who have been in receipt of large care packages at home. A negative impact is the additional staff costs and loss of income from the removal of eight beds from the system.

It was also stated that admission to the unit has prevented hospital admission and facilitated hospital discharge and has had positive outcomes for individuals, including increased independence, ability to remain at home longer, increased confidence, identification of risk (although this is also stated as a negative outcome for an individual as it resulted in a move to permanent care). Waverley staff also stated that admission to the unit resulted in individuals being able to stay in their own homes longer due to the re-skilling and empowerment of those individuals following their rehabilitation programme.

5.0 Costs & efficiencies

- 5.1** Table 1 P.17 provides an overall summary of the admissions to Waverley. It demonstrates the estimated costs and savings for each individual client as well as the estimated total costs and savings to both Scottish Borders Council and to NHS Borders for the first four month period of the pilot. It should be noted that the weekly unit cost for Waverley includes the cost of both occupational therapy and physiotherapy input which is funded jointly by SBC and NHS Borders (Appendix 2).
- 5.2** It is clear from the figures that although SBC has achieved some actual and potential savings (£6989) these appear considerably less than the potential savings to NHS Borders (£62099). The overall estimated costs and loss of income to SBC is (£45629). However it can be argued that the potential savings to SBC are in fact higher. The two cases that have 'prevented admission to care home' are showing a saving based on actual length of stay in the unit. Had they gone into a permanent care home placement the average length of stay is 22 months. This equates to a cost of £43084 per person for 22 month period. Therefore for those two clients that did not result in a permanent care home placement the saving is potentially £86168. If the pilot was to demonstrate 2 prevention of care

home admissions every four months this would result potentially in a saving of £258504 in a year. Although these calculations are partly based on estimated and potential savings and costs, they do give an indication of the potential long term impact on efficiencies for both organisations.

SCOTTISH BORDERS COUNCIL 2008/C

SUMMARY OF WAVERLEY INTERMEDI

6.0 Discussion and early recommendations

- 6.1 The overall principles and philosophy of this pilot is to support older residents of the Scottish Borders to live in their own homes as long as possible. It aims to prevent unnecessary admission to hospital, facilitate hospital discharge and prevent premature admission to residential care. The pilot so far has achieved one or more of these aims for all clients, with the exception of one.
- 6.2 Early indications from clients and key stakeholders are that this is a valuable service which fills a previous gap in the continuum of care.
- 6.3 The environment in which this service is provided appears to be suitable on the whole but requires further redesign and upgrading.
- 6.4 Teams and services appear to have adapted well to this service, some making better use than others of this resource. There has been a significant impact on specific teams and this will need to be monitored carefully. Some teams and services have not yet made use of this resource as it is centrally based and therefore not meeting the needs of each community. Early indications would suggest that there may be a need to have similar resources available in each locality area.
- 6.5 Initial fears before the project started regarding the potential impact specifically on District Nursing and GP services has not been founded. However it should be noted that the majority of clients that have been admitted to this service have been residents living in the central area and would therefore already be known to local DN and GP services.
- 6.6 There are early indications that there are gaps in this service. The pilot has demonstrated a need for general assessment beds for people who do not require hospital care. There have been several enquiries for admissions for people who do not fit the criteria according to age. Interest has also been shown from out of hours services as to the possibility of being able to refer to this service out with normal hours.
- 6.7 The data has evidenced positive outcomes for clients particularly in relation to increased confidence and safety on their return home from the unit. For some clients their stay has resulted in increased packages of care however this has allowed clients to continue living in their own homes.
- 6.8 The pilot so far has demonstrated benefits to both SBC and NHS Borders in the development and running of this service. However the figures demonstrate an inequity on impact on budget with regard to estimated costs for delivering this service. It is unclear at this stage as to whether SBC would be able to sustain the loss and cost of running and supporting this service once the pilot ends. Consideration therefore must be given at this early stage as to whether the outcomes for clients are such that both

organisations wish to develop this model of service delivery further and therefore how budgets need to be developed to shift the balance of care.

(Appendix 1)

Case study 1 – Facilitate a hospital discharge

This 76 year old lady had been knocked over and sustained a fracture of her neck of femur. This had been operated on and she was now trying to mobilise. Her husband had had a similar experience a few months before and he was still dependent on his wife.

This lady was admitted to Waverley to continue with her rehabilitation following an eleven day stay in Borders General Hospital. She had been in Ward 9 post operatively. She mobilised using a wheeled Zimmer frame and she lacked confidence to progress from this.

PMH:

Osteoporosis

Hypertension

Angina

Previously this lady had been fit and well and cared for her husband after his operation. She would need to be able to continue to assist him on her discharge.

Process

Admitted and a treatment programme completed by the Occupational Therapist and Physiotherapist for the support workers to deliver.

She progressed to two sticks very quickly.

She self medicated as per protocol and as she would do at home.

She made her own tea and meals as able, setting the table and washing dishes.

Discharge home visit

Care Manager: Central Rapid Response

Outcome

Pulses score on admission 11 out of 24

Pulses score on discharge 9 out of 24

Based on length of stay in Waverley, this reduced this lady's stay within an acute hospital bed by 13 days. If this lady had been discharged straight from the BGH she would have required a large care package for support. She did not require a care package at the point of discharge from Waverley.

This lady was discharged with minimal help from family and DNs to change her TED stockings for a few days. She was able to help her husband and get out and about as per her previous lifestyle. Rapid Response continued to provide a further 6 weeks rehab and review after discharge.

Comments from herself

“ I wish my husband could have come somewhere like this it would have been easier”

There was an email received from a family member remarking on how wonderful the service was and how supported they all felt.

Case study 2 - Prevention of admission to Care Home

A 64 year old lady living at home (Hawick area) with her husband. This lady presented with significant health issues and due to these and the breakdown in the carer's ability to continue to manage her increasing needs at home was on the verge of discussion of admission to Care Home facilities. There was extreme carer stress and he was at "the end of his tether" and felt unable to continue in this role.

PMH:

Stroke 1999 with right sided weakness

Frequent urinary tract infections

Insulin dependent diabetic

Recent deterioration in health and mobility

Low mood since hospital admission March 2008 for reduced mobility

Past history

Had been able to transfer with one and a bed lever.

Had walked with a tri-walker and some supervision.

Able to transfer on/ off the toilet independently.

Required assistance in / out of car

Transferred on/ off chair with little assistance

Managed to wash / dress with some assistance

Recent history

Unable to transfer without two carers

Unable to transfer in/ out of bed or chair

Requires carers to support to toilet.

Requires full assistance with personal care and dressing

Unable to manage diabetic regime independently

Process

Admitted and fully assessed by Occupational Therapist and Physiotherapist within intermediate care (IC) unit.

Treatment programme developed and training given to support staff within the unit.

This lady's room in Waverley was adjusted to replicate the layout at home.

Husband enjoyed a week's holiday abroad which re-energised his commitment.

Care manager in Hawick attended multi-disciplinary team meetings to plan discharge.

Home visit carried out to assess requirements for discharge and to allow carer to discuss concerns. This resulted in the decision by the lady and carer to have a profiling bed set up in another bedroom. This was to allow carers to attend at

night if required and to reduce husband's need to get up through the night, which was resulting in lack of sleep and stress. Home care support discussed and care manager arranged this.

A second home visit was provided to test the new arrangements and make adjustments to home care provision as this lady required more time to manage tasks herself.

Other assessments carried out within her time in the IC unit were:-

- Urine specimen sent to own GP and prescription for antibiotics sent to Waverley .
- Speech and language therapist assessment of swallowing. This provided evidence that this lady was at risk of aspiration. This resulted in a change to her diet. This would not have been done had she remained in the community as it had not been highlighted.
- Continence assessment.
- Diabetic Nurse assessment - changes to regime and improved control, new blood monitor which she found easier to use.
- Dentist appointment arranged and attended
- Moving and handling training provided to husband and carers.

Outcome

Discharged home with a large care package and a change to accommodation layout to enable carers to manage her needs more efficiently.

Care package before admission 14.75 hrs
Care package on discharge 17.5 hrs

Pulses score:

On admission 20/24

On discharge 18/24

This shows only a slight improvement however this change made it possible for this lady to go home and continue to be maintained there. This lady would be considered for another admission during the year if it allowed her functioning to remain stable and allowed her to continue to live at home.

The carer has been in contact with the Team Leader to express how good it is to have his wife home and it is working well. He felt her time in Waverley had been a success. His stress has reduced greatly and he now feels able to manage with the support he is receiving. They have both been out several times and have recently been away on holiday together.

Rapid Response provided a further 2 visits after discharge re: moving & handling issues/ check carers managing OK and taking on recommendations from IC staff etc. This shows the flexibility of Rapid Response staff and the need for skill transference to support SW staff.

Case Study 3 – Prevent admission to hospital

A 94 year old lady living alone at home. This lady is supported by her daughter (aged in her seventies) who lives locally. This lady was taken to A&E following a fall at home. X-ray to left ankle confirmed soft tissue injury rather than a fracture. There was also a laceration to her right elbow. This lady required physiotherapy input to improve her mobility and use of walking aids and the occupational therapist felt that this lady was unable to return home at that time.

Process

This lady was admitted straight from A&E into the Intermediate Care unit at Waverley. Previously this lady mobilised independently. The Intermediate Care team worked on improving mobility and improved confidence to manage at home. It was also noted that this lady's daughter was also unwell due to a chest infection and required her own treatment and recovery time.

Outcome

Pulses score on admission 12 out of 24

Pulses score on discharge 9 out of 24

Increased mobility, walking with one stick, balance excellent (having improved).

Carrying out kitchen tasks and folding laundry.

Increase mood

Increased confidence

This lady's daughter felt that she was now able to cope at home as her mum was more mobile and more confident.

(Appendix 2)

Scottish Borders Cou Cost of Intermediate

Description

Staff Costs:

Management Time

2 x Social Care Assistan

1 x Social Care Assistan

1 x Night Staff (Social C

1 x Night Staff (Social Care As

(Appendix 3)

Scottish Bord Breakdown o

Cookworks Signatu

Morphy Richards It

Deco, Carpets & Kit

References

Changing Lives, 21st Century Social Work. 2005. 21st Century Social Work Review – Interim Report. Available from <http://21csocialwork.org.uk>

<http://www.isdscotland.org/isd/4434.html>

Intermediate Care in Scotland A Partnership Approach Scoping Report Joint Improvement Team SE June 2007

SCOTTISH EXECUTIVE 2006b *Changing Lives: Report of the 21st Century Social Work Review*. Edinburgh. Scottish Executive.

SCOTTISH EXECUTIVE 2007g *Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland*. Edinburgh. Scottish Executive.

SCOTTISH EXECUTIVE 2005c *Delivering for Health*. Edinburgh. Scottish Executive.

INTERMEDIATE CARE & REHABILITATION PROJECT

WAVERLEY CARE HOME PILOT

Criteria

All of the following criteria must be satisfied before a person can be admitted to Intermediate Care (IC) unit

- Must be an adult – for the purposes of the pilot which is part of the Older Peoples Best Value Review, the person should be 55 years and above.
- The person would otherwise have had to be admitted or to remain in hospital/care home
- The person must have motivation and therefore be suitable for rehabilitation
- Rehabilitation programme will be based on individual need and will not normally require longer than a six week programme
- There must be an identifiable Core Adult Assessment Document, Care Plan and Discharge Plan underway on admission to IC unit
- The person must be medically assessed by their GP, Consultant or Nurse prior to admission to the IC unit using current procedure and a Gpass summary/Immediate Discharge Letter available.
- Nursing/Allied Health Professional Treatment Plan Summary should follow the client/be available on admission.

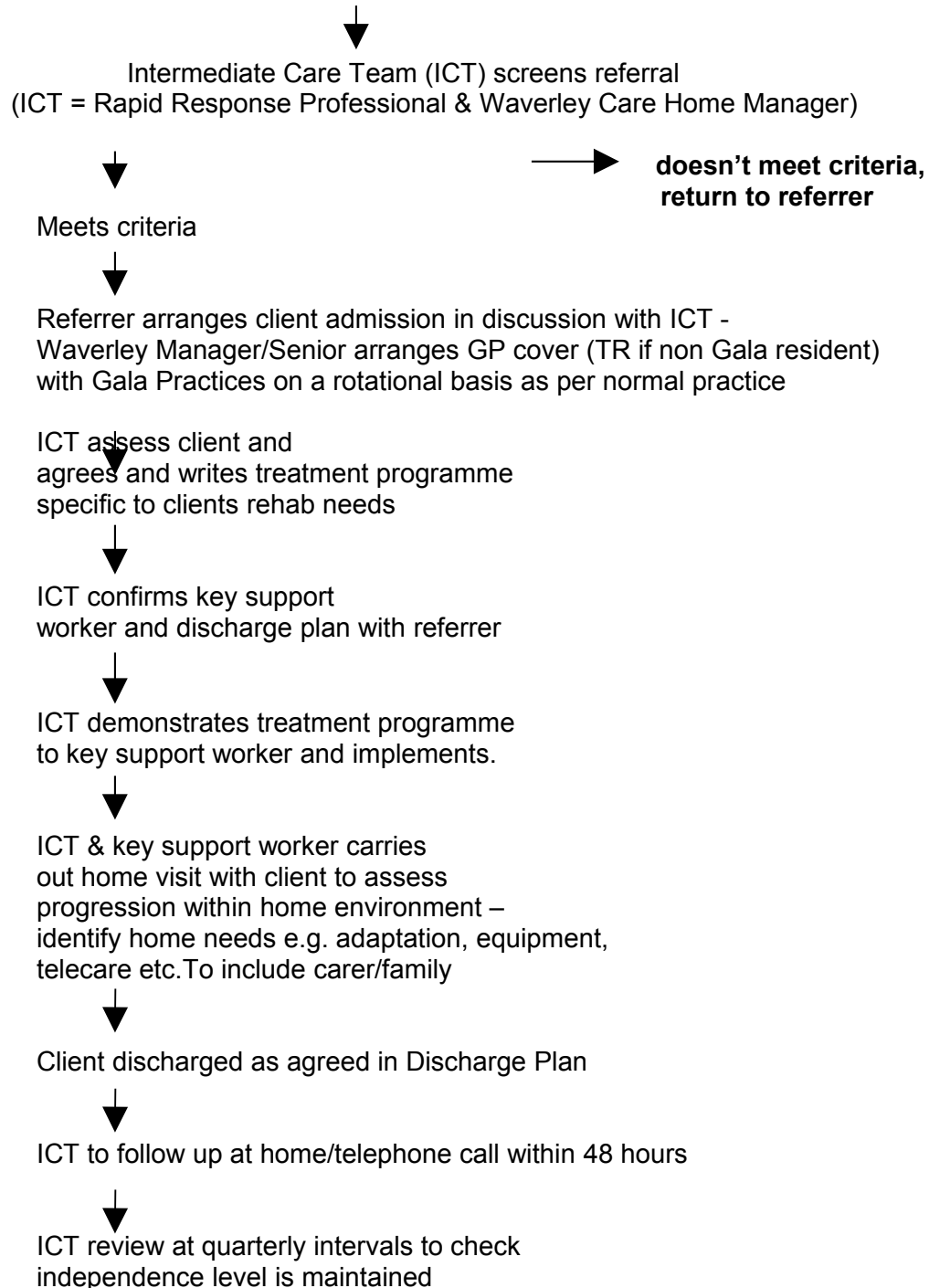
Notes to support criteria

- Referral can be made by
 - Person's own GP/ /District Nurse/ Consultant
 - MDT within Hospitals
 - Rapid Response Team
 - Social Work team
 - Discharge Liaison Team
- Waverley Manager/Senior arranges GP cover (Temporary Resident status if non Gala resident) with Gala practices on a rotational basis as per normal practice. GP requests own practice DN to complete SSA referral document if one is not already under way by another team/service. The medication protocol must also be followed – see attached.
 - Should the person in the IC Unit require medical intervention out with the normal working day the OOHs service should be contacted as per normal practice.
- Rehabilitation programmes will normally be up to 6 weeks.
- The focus of the treatment programme will be on enabling independence.
 - Referrals can be made Monday to Friday 09.00 to 17.00 by fax to the Manager, Waverley Residential Care Home 01896-755377.
- Admissions can be taken 08.00 to 20.00, seven days a week.

Intermediate Care & Rehabilitation Project

Waverley Care Home Pilot Referral Process

The Core Adult Assessment Document (CAAD) sent to Waverley Care Home Manager.
The full CAAD, Care Plan & Discharge Plan which must be underway should follow



Discharge plan and checklist – to be commenced by referrer/care manager and completed in conjunction with Intermediate Care professional.

| | |
|--------------------------------------|---------------------------------------------------------------------------------------|
| Framework ID: CHI No: Address: | Estimated Date of Discharge: Name of Carer/relative: Carer/relative Contact No: |
|--------------------------------------|---------------------------------------------------------------------------------------|

Preparation for admission to Waverley

Admission plan to Waverley discussed and agreed with client and carer: Yes No

Transport arrangements on admission please describe:

Medication: Yes No MAR: Yes No

Aids required eg medication compliance aid, zimmer, spectacles, hearing aids
 Yes No please state:

Preparation for Discharge from Waverley

Discharge plan from Waverley discussed and agreed with client and carer: Yes No

Discharge education, advice, information given to client and carer: Yes No

Transport arrangements on discharge please state:

Compliance Aid required: Yes No

Bordercare Alarm required: Yes No

Telecare Provision required: Yes No

GP letter sent: Yes No

DN informed: Yes No

SW informed: Yes No

Sheltered Housing Warden notified: Yes No

Essential food, heating, water in situ: Yes No

Equipment/Aids required eg handrails, bathing aids etc please state:

Signatures:
Care Manager: **Intermediate Care Worker:**

Date:

Waverley Intermediate Care Patient Medicine Arrangements

Pharmacy Department

1. Patient from Home or Community Hospital, ie under GP care
 - a) Patient + Own Medicines or Own Compliance Aid admitted to Waverley
 - b) Patient must also have prescription for up to 8 weeks issued by their own GP with them
 - c) Prescription taken to Lloyds, Gala by Waverley staff
 - d) Lloyds, Gala, will dispense this supply (covering up to 6 weeks stay and 2 week discharge supply) either as medicines for self-administration by patient or as weekly compliance aid/Nomad boxes. All patients will have a MAR Chart issued by Lloyds Pharmacy Galashiels.

2. Patient from BGH or seen in BGH A&E (a and b might not apply)
 - a) Immediate discharge letter (IDL) written. Discharge liaison team responsible for annotation "**Patient for Waverley Intermediate Care Bed**", so BGH Pharmacy procedure is followed.
 - b) BGH Pharmacy will deal with discharge medicines in usual way, ie PODs supplied for patient or 1 week supply dispensed in a compliance aid (MTS) what does this stand for?
 - c) Blue Hospital prescription (HBP4) to be completed by registered medical practitioner on ward for up to 8 week supply of medicines. Discharge liaison team will obtain HBP4 form and return completed form to Pharmacy so medicines and prescription are assembled for individual patients. BGH Pharmacy will deal with any interventions before patient leaves BGH so it is essential HBP4 form is seen as well as IDL.
 - d) This script goes with patient and medicines to Waverley. Then follow 1. c) and d) above.

Any difficulty in medicine supply to be referred to BGH Pharmacy.

General

1. Medicine Storage – in locked medicine cabinets for individual patients in individual rooms.
2. Changes to drug treatment.
New or amended medicines required- GP10 form to be written and dispensed by Lloyds Pharmacy, Galashiels. New MAR sheet to be provided reflecting changes.
3. Within Waverley people are encouraged to self medicate. This is supported by the Social Care and Health Medicines Management Guidelines. If a person is unable to self medicate the recommended procedure within these guidelines is followed.
4. Lloyds Pharmacy Tel/Fax No 01896 755948

Intermediate Care & Rehabilitation Project

Contingency Planning

Bed Management

- The Intermediate Care Unit will work to an eighty-five per cent occupancy rate based on the following formula
 - $7 \text{ divided by } 100 \times 85 = 5.95$

This means that there will a maximum of six beds occupied at any given time which will prevent bed blocking.

- Admissions will be managed by the Care Home Manager or his deputy to allow for appropriate turn around time.
- It is recognised that there may be some individuals that do not fully achieve their expected outcomes or are found not to be suitable for rehabilitation.

If an individual does not fully achieve their expected outcomes within their estimated length of stay they will be discharged to their own home or other place of residence and followed up by Rapid Response Team, if this meets criteria, as per normal practice. If the individual's medical needs have increased to a point that they require admission to hospital then the original referrer or delegate, as nominated on admission to the Intermediate Care Unit, is contacted to make the appropriate arrangements. The referrer needs to be notified of this as early as possible. The referrer is expected to make suitable arrangements within no longer than three working days.

Should the individual be found not to be suitable for rehabilitation and require to have a permanent care home provision, the referrer will be notified who will make arrangements for the individual to return to their own home and the normal procedure followed.

Staffing

- Social Care Assistants/Workers (SCA/Ws) from within Waverley Care Home will staff the IC unit and deliver the treatment programmes. Should there be a staffing shortage within Waverley Care Home the normal course of action will follow ie provision of bank/agency staff. It is anticipated that the bank/agency staff will support the residential sections of Waverley whilst the existing SCA/Ws will continue to support the Intermediate Care Unit. This will provide consistency with skill base levels.
-
-

-
- This will be managed by the Care Home Manager or deputy. Should there be a shortage of existing SCA/Ws that have developed Rehabilitation skills then it is anticipated that the Home Care Assistants
-
- (HCAs) that support the Rapid Response service will provide support until the problem has been rectified. This may be through direct hands on support, demonstration or shadowing. This will be agreed in the first instance with Annette Fleming Home Care Manager and Shona Cavers Rapid Response Team Leader.
- **Rapid Response**
If there are staff shortages within the Rapid Response team to develop treatment programmes links will be made with other staff within their professional group to aid the process. In the event of the dedicated IC professional being unable to attend the multidisciplinary team meetings within Waverley they will liaise and be deputised at the meeting by another Rapid Response team member.

WAVERLEY CARE HOME PILOT
FILE AUDIT TOOL

| | File Format Timescales | Task Responsibility | Completed Date & Initials |
|----|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------|
| 1. | CAAD Form/Care Plan/Discharge Plan into Waverley with screening outcome clearly documented on this form Day of request | Referrer Nigel & Shona to agree screening outcome | |
| 2. | Medical Assessment/GPass Summary to include MAR & Medication Prior to Admission | Referrer & Nigel | |
| 3. | OT & PT Assessment including Pulses Scoring Within 48 hours of admission & on discharge | OT & PT | |
| 4. | Needs & Outcomes Document Within 48 hours of admission | OT & PT | |
| 5. | Treatment Programme Within 48 hours of admission | OT & PT | |
| 6. | Treatment Programme Review Weekly or sooner as per individual need | OT & PT | |
| 7. | Treatment Programme Feedback Daily | SCAs/Workers | |
| 8. | MDT Action Plan Weekly | Nigel | |
| 9. | Discharge Plan Reviewed & amended weekly | Nigel & Care Manager OT & PT to inform the process | |
| 10 | Home Visit Report Within 48 hours of visit | OT & PT | |
| 11 | Client Questionnaire Day before Discharge | Nigel | |
| 12 | Evaluation Data Recording Sheet On admission and Discharge | Nigel | |

Please Note: Waverley Care Home Manager has overall responsibility to ensure that the file format is correct and up to date.

WAVERLEY CARE HOME PILOT
DATA COLLECTION SHEET

| | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------|------------------------|------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------|----------------------|---------------|
| Name | | | | Address | | | | | |
| Frame work ID | | | | Post Code | | | | | |
| Date of Birth | | | | Tel | | | | | |
| CHI Number | | | | G.P. | | | Sex: M F | | |
| Date of Referral | | | | | | | | | |
| Referrer: Please state team/service /person | Acute | Comm. Hosp | Social work team | GP | District Nurse | A&E | DLT | RR | Other |
| Diagnosis: | Ortho/fall | Neuro | Cancer | Surgical | Mobility | Medical | Respiratory | Psychiatric | Other (state) |
| Reason for Referral: | | Prevent admission to hospital | | | Prevent admission to Care Home | | | Facilitate Discharge | |
| Date of Initial Screening: | Date Admitted: | Date of Assessment in IC Unit: | | | Reason for Delay of Admission: Specify ie beds unavailable, staff capacity, awaiting GP/Con.letter, medication etc | | | | |
| Reason for Refusal: | Medically Unfit | Unmotivated | Unable to Rehab | | Independent | Other | | | |
| Estimated Date of D/C: | | Actual Date of D/C: | | | Actual Length of Stay: | | | | |
| Discharge Outcomes: | Home | Family | Community Hospital | Acute Hospital | Permanent Care Home | Other (specify) | | | |
| Transport Arrangements: Please specify if own car, family, voluntary services (name), taxi, professional ie SW etc | | | | | | | | | |
| Care package on admission: | | | | | Care package on Discharge: | | | | |
| Type of Professional Involved: | | Specific Nursing Input Required Yes No | | | | Specific OT Input Required Yes No | | | |
| | | Specific Physio Input Required Yes No | | | | Specific SW Input Required Yes No | | | |
| Other Services Involved during stay in IC Unit: | | Housing | Day Hospital/ Day Care | | | Voluntary Service | Welfare Benefits Office | | |
| | | Mental Health | Other (specify): | | | | | | |
| Admission / re admission to hospital during IC Stay: | | | Medically unfit/unwell | | | Rehabilitation Unsuccessful | | | |
| Pulses Scoring Tool | | | | | | | | | |
| Dependency levels on admission: | | | | | | | | | |
| on discharge: | | | | | | | | | |
| quarterly review: | | | | | | | | | |



Intermediate Care Service

Enabling Independence

Scottish Borders Council and NHS Borders are developing a range of Intermediate Care services which will provide rehabilitation for people following a period of illness, injury or incapacity.

This leaflet provides information about Intermediate Care.

What is Intermediate Care?

This is the term used to describe a number of services that provide short term support to enable independence by avoiding unnecessary admission to hospital or long term care, or to help following discharge from hospital.

It is often referred to as a 'bridge between hospital and home', between dependence and independence.

Intermediate Care can be provided in a range of settings such as people's own home, within a residential care setting or within a local Community Hospital environment.

Intermediate Care in the Scottish Borders

There are several examples of Intermediate Care services in the Scottish Borders. These include community based teams such as the Rapid Response Team and the Community Health Teams. These teams help people to return to, or remain in, their own homes.

If you are finding it difficult to manage at home and may benefit from extra support for a short time, you can receive an Intermediate Care service within Waverley Residential Care Home in Galashiels or within your local Community Hospitals.

It can provide you with a place to rebuild your energy, skills and confidence following a period of inability.

The process of offering you this help, professional advice, support and encouragement is what we call rehabilitation.

How do I get the service?

You can be referred by either your community or hospital team e.g. district nurse, social worker or acute hospital discharge team. The

referrer will submit your information to the appropriate service to ensure that your stay, care and return home are all managed efficiently.

Once you are referred, you will be assessed by the multi-disciplinary team.

During your assessment it is important for us to find out what you would like to achieve and therefore we need you to take an active part in your rehabilitation. You will be encouraged to set goals to help you return to your previous level of independence or increase your ability to manage at home.

Referrals can be made Monday to Friday 9.00am to 5.00pm. Admissions can be taken 8.00am to 8.00pm, seven days a week.

Your Rehabilitation Team

Occupational Therapist – will work with you to devise techniques to help you carry out every day tasks at home such as washing, dressing, cooking, getting out and about.

Physiotherapist – will show you exercises to improve your balance and strength – walking indoors, outdoors and managing stairs.

Nurse – will work with you through your rehabilitation period to help with your health and social care needs.

Key Support Worker eg. nursing auxillary, social care worker, home carer – will support you with your individual activities and exercise programme. This is known as your treatment programme.

Your team will make sure you feel confident on your return home and have the services and equipment you and your family need.

What we expect from you

- Take an active part in your treatment programme.
- Practice each day to build your confidence, strength and skills.

- Use the support and supervision provided by the team.
- Be willing to continue to work on your treatment programme at home if appropriate.

Will I have to pay?

Intermediate Care is a free service for up to six weeks. However if your treatment programme includes practicing certain tasks such as cooking and shopping, you may be asked to pay for any associated additional costs eg food products, taxi should this be an expected activity for you to carry out when you return home.

If you need social care services after that, you will be assessed for these by your referrer and there may be a charge.

Where can I get more information?

For more information about the service, you can speak to your district nurse, social worker or hospital discharge team.

You can also contact the:

Care Home Manager
Waverley Residential Care Home
Elm Row
Galashiels TD1 3JG
Tel/Fax: 01896 752659

Haylodge Community Hospital
Ward 2
Neidpath Road
Peebles
EH45 8JG
Tel 01721 722080

Knoll Community Hospital
Station Road
Duns
TD11 3EL
Tel 01361 885000

Crumhaugh Hospital
Crumhaugh Road
Hawick
TD9 0BA
Tel 01450 372646

Coldstream Community Health Team

Tel 018909 82711

Jedburgh Community Health Team

Tel 01835 863361

Rapid Response Team

Kelso Tel 01573 227977

Duns Tel 01361 884771

Selkirk Tel 01750 23880

Hawick Tel 01450 361009

Peebles Tel 01721 726999

Discharge Liaison Team

Borders General Hospital

Tel 01896 826075

You can get this publication on tape, in large print, and various computer formats by contacting us at the address below. In addition, contact us for information on language translations, additional copies, or to arrange for an officer to meet with you to explain any areas of the publication that you would like clarified.

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Scottish Borders Council
Council Headquarters
Newtown St Boswells TD6 0SA
Tel. 01835 825080

Information on the full range of
Social Work Services is available on the Council's
website at:

www.scotborders.gov.uk

