INTERMEDIATE CARE IN SCOTLAND

A PARTNERSHIP APPROACH

SCOPING REPORT

June 2007

Summary

An increasing number of intermediate care projects are being developed by partnerships in Scotland. While 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 whole system working. However, across Scotland each project or development has arisen in response to different local circumstances. As a consequence there are a range of different approaches for service provision, differing funding and organisational arrangements. The aims, objectives and outcomes may vary and different information is available to support the evaluation of quality and effectiveness.

The participants of the Intermediate Care Learning Network have shared information about the current developments in Intermediate Care within their own services and areas. The purpose of this information is to inform policy makers, planners and practitioners about the range of work currently underway. The report does not attempt to provide a comprehensive view of all the services that might conceivably be included in Intermediate Care. This report describes the activities and outcomes but does not evaluate the effectiveness of any individual project.

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.

Across Scotland, a number of people have expressed a strong preference to avoid using the term “Intermediate Care” and have suggested that we consider the term “interface services” i.e. the essential services at the interface between hospital care and ongoing community support, for patients at a time of transition.

1. The Joint Improvement Team

The Joint Improvement Team (JIT) is sponsored by the Scottish Executive, the Convention of Scottish Local Authorities (COSLA), and NHS Scotland to work directly with local health and social care partnerships. The JIT aims to accelerate the pace of improvements delivered by health and social care partnerships with the objective of achieving service improvements for the benefit of service users and carers.

Helping partnerships to address the pressures and causes of delayed discharges from hospital is a particular focus across all the work of JIT. The JIT supports service developments in key action areas by working with select partnerships on specific projects and using the outcomes to support wider developments across the country. Discussions with partnerships and other stakeholders during consultation identified Intermediate Care as an important area in which to undertake service development and good practice development work.

2. Intermediate Care

Intermediate Care is a generic term that covers a wide range of services that help prevent unnecessary admission to hospital, or help facilitate early discharge. As such, the term refers to a very important range of services that can help reduce delayed discharges. Intermediate Care services enable people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community settings.

The term Intermediate Care has not been commonly used or defined in Scotland in the past. However, local partnerships are increasingly identifying the potential benefits that could be realised by developing Intermediate Care services.There is no commonly agreed definition of intermediate care in Scotland, and the Intermediate Care Learning Network have agreed a working definition so all participants are clear about the parameters of the term and share a common understanding.

The term has been defined as a "*range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living*".[1]

The Oxford and Anglia Intermediate Care Project definition is:

> "*Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team*."[2] This includes:

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

[1] National Services Framework Older People, DOH, June 2002
[2] Oxford and Anglia Intermediate care Project, 1997

This definition fits with the developing tradition of extended primary care teams in Scotland delivering a service, either in the patients own home, or as close to the patient's own home as possible.

A more recent generic definition has been used by the Change Agent Team which also indicates the broad range of services included is as follows:

> "*Intermediate Care is a service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care*"[3]

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

The Intermediate Care Learning Network in Scotland supports a whole systems approach to service design and delivery and therefore supports the development of Intermediate Care services as part of a range of services needed to maintain people in their own homes wherever possible. There must be effective communication between all parts of the system and care must be taken to ensure that there are clear links between specialist care teams, primary care services and social work services. Intermediate care services therefore are able to act as bridges at key points in *transition* in the patient's journey from hospital to home (or visa versa) and from illness to recovery.

The key features of Intermediate Care in Scotland have been discussed by participants in the Intermediate Care Learning Network and they have agreed that Intermediate Care should:

- Include integrated and focused services;
- Maximise Independent Living;
- Prevent unnecessary hospital admission;
- Support timely discharge;
- Be focused on those whose needs are complex and in transition;
- Be relevant to all adult care groups and generic and specialist services;
- Be time limited and focused interventions according to the needs of the user;
- Have flexible timescales although recognition that there is a need for intervention to be time limited;
- Provide an ongoing rehabilitative approach; and
- Have a clear patient pathway which connects services for patients.

The services can be provided in a range of settings including:

- Individuals own homes including sheltered housing and very sheltered housing
- NHS Day hospitals and LA day centres
- Designated residential and nursing homes

[3] Making Connections, 2006

- Community Hospitals

Examples of Intermediate Care services can include:

- Community assessment and treatment teams;
- Joint community rehabilitation teams;
- Rapid response services;
- Intensive care at home schemes;
- Extra care housing developments and telecare developments;
- Alternative use of residential and nursing home provision;
- Innovative use of community hospital facilities; and
- The work of extended primary care teams.

3. Key Characteristics of Services in Scotland

In Scotland it is clear that Intermediate Care services are an important part of whole systems planning as emphasised in recent policy documents. The JIT intermediate Care Programme is set in the context of national and local priorities including:

National Outcomes

- Supporting more people at home, as an alternative to residential and nursing care
- Assisting people to lead independent lives through reducing time spent inappropriately in hospital and enabling supported and faster discharges from hospital
- Ensuring people receive an improved quality of care through faster access to services and better quality of services
- Better involvement and support for carers

National targets

- Emergency admissions: by 2008/2009 a 20% reduction (for two or more admissions) compared to 2004/2005
- Integrated Home Care: by 2008 increase number of older people receiving intensive home care to 30% (of all people in receipt of long term care)
- Delayed Discharge: by April 2007 there should be 50% reduction in the number of people delayed beyond 3 days in short stay beds (35 nationally agreed acute specialties), and 6 weeks in all other specialties. By April 2008 there should be further reductions so there are no delays beyond these timescales.

Delivering for Health – sets the direction for:

- provision of local services;
- a shift in the balance of care from the acute sector to the community;
- the development of community hospitals and resource centres;
- closer integration of health and social care;
- the role of CHPs in improving access, supporting people at home, avoiding inappropriate hospital admissions; enabling appropriate discharge and rehabilitation.

21st Century Social Work – sets out expectations of social work services including:

- the design, planning and delivery of services should be influenced by service users
- carers should be recognised as active partners and care providers
- there should be clarity about how to access services
- there should be effective joint service planning and design arrangements
- the contribution that social work makes to achieving shared priorities should be respected and valued

The recent publication of the Community Hospital strategy[4] will be very relevant to the provision of intermediate care services.

The Joint Performance Information and Assessment Framework provides the opportunity to develop local improvement targets relevant to the national priorities and local circumstances. Intermediate care services will contribute to the provision of a whole systems approach and help promote an effective balance of care.

Partnerships for Care emphasised the importance of "supporting people with long term conditions and the need for effective partnership working and co-ordination of care across the health and social care spectrum."

The Framework for Joint Services for Older People highlights the kind of joint services, including intermediate care, for older people who need enhanced care.

Developments in policy and legislation now provide a robust framework to support the development of integrated health and social care services to support people as far as possible in their own homes and communities, and work is underway across Scotland to consider how to provide appropriate care for people who require more support than is normally provided through community, social care or primary care services, but who do not require the intensive services available in an acute hospital.

4. Intermediate Care Learning Network

To help promote effective delivery of Intermediate Care services, JIT has established an Intermediate Care Learning Network to help share good practice and information about Intermediate Care. The Learning Network was established with a remit to:

- Identify and share examples of what works and key challenges at local level
- Support the development of emerging integrated intermediate care models, including anticipatory and preventative services in a number of Partnership areas
- Commission scoping and evaluation of services
- Develop key outcomes in line with local and national priorities and targets
- Support development of related work programmes such as community rehabilitation framework,
- Collate, contribute to and publish good practice/key indicators to support the implementation of national policy
- Organise regional and national seminars

[4] Developing Community Hospitals: A Strategy for Scotland. December 2006

- Support the development of integrated health and social care developments
- Support engagement of users and carers
- Utilise JIT website to publish information

The Intermediate Care Learning Network acts as the core reference group to agree and oversee a work programme which includes:

Learning Network Meetings – Identifying and sharing examples of what works at a local level. The learning network acts as a national group interested in developing practical intermediate care initiatives in Scotland. The group aims to share examples of what works at a local level and commissions scoping work to collate information across Scotland.

Development and Evaluation Work – There is ongoing work in Ayrshire and Arran and other areas to support the development of emerging intermediate care models and evaluate the range of models in place. The Joint Improvement Team assists in the evaluation of these models to inform further developments.

Collation and Publication of Practice that works – This area of work includes: a report setting out examples of Intermediate Care in Scotland and UK; Organisation of National Seminar to publish and promote information on Intermediate Care; and use of the JIT website to publish materials about Intermediate Care.

Policy Links – Links are maintained and developed to ensure there is correlation with other initiatives within the Executive, NHS Scotland and COSLA where developing intermediate care is of relevance (for example, Development of Rehabilitation Services, Reducing Readmissions, Delivering For Health, Delayed Discharge, etc).

5. The Range and Scope of Intermediate Care Services in Scotland

An increasing number of intermediate care projects are being developed by partnerships in Scotland. While 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 whole system working. However, across Scotland each project or development has arisen in response to different local circumstances. As a consequence there are a range of different approaches for service provision, differing funding and organisational arrangements. The aims, objectives and outcomes may vary and different information is available to support the evaluation of quality and effectiveness.

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Appendix 1 provides specific information about each of the developments included in this report. Appendix 2 provides contact information for members of the Intermediate Care Learning Network.

5.1 Intermediate Care Services / Developments

Across Scotland there are a range of service developments that can be considered as Intermediate Care Services. These include non-residential community services such as:

- Community Rehabilitation Services
- Rapid Response Services
- Crisis Care

These services are usually linked with other community services for example Community Alarms / Assistive Technology, or Home Care Teams.

Some areas of service have a specific focus on enabling people to be discharged home from hospital. e.g. Early Supported Discharge
These services are often integrated with hospital services and discharge processes.

For some service users who have complex needs there may be more intensive Intermediate Care services available, either in their own homes or in a designated facility, such as Intensive Care at Home or Residential intermediate Care Facilities.
These more intensive services normally have specified arrangements for medical cover and a higher level of nursing input.

In several areas developments are underway that consider specific aspects of Intermediate Care, for specific client groups or considering underpinning / enabling factors:

- Intermediate Care for Older People with Dementia
- Community Alarms / Assistive Technology
- Competencies for staff working in Intermediate Care

5.2 Aims of the Service / Development

Although individual elements of service may focus on a particular process e.g. hospital discharge, all the Intermediate Care Services included in this report are trying to enable people to remain in their own homes by reducing hospital admission and facilitating hospital discharge. In general most services include the following aims:

- Prevent unnecessary admissions to hospital
- Help people to remain in their own homes
- Provide opportunities for more intensive assessment and rehabilitation to reduce admission to residential / nursing home care
- Provide appropriate settings for rehabilitation (step down / alternative to hospital care)
- Progress discharge from acute hospital (avoid delayed discharge)
- Maximise independence

5.3 Models of Intermediate Care

5.3.1 Client group

The majority of intermediate Care Services cater for the needs of Older Adults and in particular, the frail elderly population. In many instances, although there is no defined age limit, the majority of service users are aged over 75 years. This reflects the complexity of conditions and care needs that this group have and their requirements for more intensive rehabilitation and support to enable their continued independence.

In most services, a significant proportion of service users are referred following orthopaedic trauma. Some services also provide services for other client groups, for example, stroke rehabilitation.

There are common concerns about the level of specialist support and rehabilitation for people with dementia. For many of these patients, the transition from one service to another can be a time of marked deterioration in their cognitive and functional ability. Some partnerships are considering the development of specialist intermediate care services for people with dementia and a separate report is available about this work.[5]

5.3.2 Referral source

Most Intermediate Care services receive referrals from a variety of sources, both in the community and from hospital based services including:

- Social Work
- GP / Primary Care Team
- Older People's services
- A&E
- Acute hospital services (medicine, orthopaedics)
- Hospital Discharge Teams

The IRIS project In Glasgow reports referrals sources as follows:

Orthopaedics	18%
Rehabilitation Medicine (Elderly)	18%
Rehabilitation Medicine (Assessment)	13%
A&E	11%
GP	9%

with these 5 referral sources accounting for almost 70% of referrals.

In some areas there is a specialist Physician Assistant or Physician / GP role based in medical receiving and these roles are key in liaising with community and Intermediate Care services to arrange appropriate alternative care when hospital admission is not necessary.

Although most Intermediate Care services have good links with GP Out of Hours services and Emergency Social Work Services, the links with NHS 24 are not so well developed. Some service providers have developed information sheets, available to local organisations to enable them to make more appropriate direct referrals to services.

[5] Intermediate Care Services for People with Dementia. Seminar Report, March 2006. (available from www.jitscotland.org.uk)

5.3.3 Service model

There is great variety in the models of Intermediate Care across Scotland. The 3 major areas of difference are:

- Residential / non- residential services;
- Times when services are available / referrals can be made
- Components included within Intermediate Care

The majority of services are either community based, or residential based, with a small number of services (Angus, Aberdeen) offering both models from within the same team. Residential services have a high level of overhead cost and are suitable for people whose home environment is not suitable or where intensive home care support services are not available or would be prohibitively expensive. In some areas there is a dedicated Intermediate Care facility, whilst in other partnerships, beds are used in existing residential or other care facilities. Evaluations of Intermediate Care in England show residential Intermediate Care to be effective in increasing the independence of individuals and improving their quality of life.

The time when services are available has a considerable impact on the options available when a service user needs support. Some services accept referrals during normal daytime service hours, 5 days per week. Other services have extended admission/service hours, and some services are available every day of the week. In some hospitals short term (23 hour) wards are being considered to enable patients to be given support and care out of hours when hospital admission is not deemed to be appropriate. This aspect of interface between services is considered to be extremely important in preventing different care routes, and potentially different outcomes, for people admitted at differing times of the day or week.

Because there is no standard definition of Intermediate Care, the components included in services varies. In particular Rapid response services and crisis care services are often not included alongside Intermediate care services where these have been separately established. The key issue is not whether services are termed as “Intermediate Care” but how well they are co-ordinated to ensure a smooth patient flow through the possible referrals pathways.

5.3.4 Eligibility criteria

The majority of Intermediate Care services will only accept patients / clients who are suitable for rehabilitation (i.e. medically able and motivated). Some services in Aberdeen also provide services for people with terminal illness.

Where only those suitable for rehabilitation are accepted there is sometimes a concern amongst other AHPs in the community that they will only see less able clients and that staff skills and motivation will be difficult to maintain.

Some Intermediate Care services do not consider that they have sufficient skilled workers or suitable facilities to care for people with dementia alongside other older people. In such instances people with moderate or severe dementia are excluded from the service.

Several Intermediate Care services are directed at supporting older people so in many areas only those over 65 are eligible for services. In practice, many service

users are over 75 reflecting the higher need for care and support to enable rehabilitation for this group.

5.3.5 Social Care Support

In addition to social work / social care staff who are directly involved in Intermediate Care, effective services usually have good links with other services including Home Care, Care Management, and Residential Homes. Where clients are not previously known to social services, Intermediate Care services may have an important role in undertaking assessments and completing Single Shared Assessment paperwork.

5.3.6 Health support

All the Intermediate Care service described in this report employed a range of AHP staff, and the majority had dedicated nursing staff or agreed nursing input from district nursing. There is a wider range of medical input that varies from no additional or specialist input (patient remains under the care of their own GP), through dedicated GP or Community Geriatrician sessional input, to services that are Consultant Geriatrician led.

5.4 Partnership Working

Intermediate Care services are more effective when planned and delivered in partnership between primary and secondary health services, local authorities, and the voluntary and independent sectors. This whole-system approach to care provision seeks to provide better outcomes for users and carers, whilst also making more effective use of capacity within the wider health and social care system.

Links with acute hospital services tend to be relatively good in relation to enabling discharge, and in several places, there are well developed mechanisms for preventing unecessary hospital admission (Edinburgh, Aberdeen, Glasgow). In East Renfrewshire and Angus there are examples of good follow through during a patient’s hospital stay, but several services report that contact can be broken with patients during prolonged hospital stays, decreasing the co-ordination of service delivery.

Most Intermediate Care services described examples of good links with GPs and the extended primary care teams, however it could also be difficult to engage with GPs to keep them informed about services.

Partnerships described some difficult links with home care, or mainstream physiotherapy or occupational therapy (OT) services, who may percieve that they are left to sort out the ongoing support requirements. Increased care at home, as an alternative to residential care, leads to greater requirements for on-going home care services and increases pressure on budgets. If the transition is not smooth between Intemediate Care services and the teams providing longer term care and support, there may be gaps in service provision.

In Aberdeen, the Smithfield Court development is a collaboration between NHS, Social Work and Housing. However, in most partnerships there is probably much more work to do with Housing, particularly in the provision of very shltered accommodation, and greater use of community alarms and assistive technology.

Some contributors (East Renfrewshire, North Ayrshire) gave tangible examples of how voluntary organisations are linked in with the provision of intermediate care services, for example voluntary transport services or the involvement of condition

specific groups e.g Alzheimer's Scotland. Most contributors whilst recognising the valuable role that voluntary organisations could and should play, often did not include them in the planning phase of service delivery.

5.5 Outcomes

All Intermediate Care services were clear on the benefits and outcomes of their services, including:

- Supporting more people at home
- Reduced time in hospital
- Enabling faster discharge from hospital
- Increased independence
- Improved quality of care as determined by individuals and their family / carers
- Faster access to some services
- Shift in care from acute to community settings
- Reduced admission to residential / nursing home care
- Increased the provision of local services

Several Intermediate Care services reported examples where as a consequence of their service, clients had been able to reduce their existing package of care. Although these benefits could be monitored for the individuals involved, in general, changes such as increased independence, were not measured over the long term, or compared with other similar groups.

Intermediate Care services also reported examples of prevented admission to residential / nursing home care. Whilst these are positive outcomes for the individuals involved, these changes increase the requirement for home care support and intensive or complex packages of care.

5.6 Financial Information

Across the Intermediate Care services included in this report there is a wide range of funding arrangements. Some services are funded mainly by one agency (NHS or Social Work). Where services are jointly funded, the service is often managed by one agency. Funding for Intermediate Care services is from a range of sources:

- Resource transfer
- Winter pressures money
- Service reconfiguration / redesign
- Core funding

Not all funding is available on a long term basis, particularly where a portion of the service is supported through winter pressures money. Where services have been developed on a project basis, the long term funding may not be secure.

5.7 Evaluation

For most Intermediate Care teams there is evaluation of aspects related to the delivery of the service including:

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

In some services there is follow up in the short term, but to date there have been no long term studies on the impact of Intermediate Care services. There is no robust comparative information and no published cost-benefit analyses.

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

Increasing or maintaining independence at home will impact upon the carers of an individual. It would be valuable to collect more detailed information about this aspect of support, for example, levels of carer support required, satisfaction with the service, extent of involvement in increasing and maintaining independence. This would assist in the development of local strategies to support carers in their role of enabling people to remain in the community.

5.8 Future Developments

Several of the Intermediate Care Services have been established as a pilot within their area. Extension of these services depends on evaluation of the outcomes and effectiveness of the services and on availability of resources. Partnerships felt it would be helpful to have audited examples of good practice published.

In the future intermediate care teams would like to see better links with local housing support services, to enable people to remain safely in their own homes and communities.

There was some feedback that Intermediate Care should be part of strategic planning and that at present there was too much ad hoc development. This could lead to duplication in some areas of service, and absence of clear patient pathways through a multitude of service options.

6. Intermediate Care In England

There have been 2 recent evaluations of Intermediate Care in England

- Institute of Health Sciences and Public Health Research, University of Leeds (2005)
- Health Services Management Centre, University of Birmingham & Leicester Nuffield Research Unit, University of Leicester (2006)

Despite having a clearer definition of Intermediate Care in England, the reports describe the great diversity in Intermediate Care services which made comparative evaluation extremely difficult.

In general, all Intermediate Care services set out to maximise independent living. Services were provided in range of settings (residential and non-residential), and were directed towards the prevention of admission and supported discharge.
Services focused on periods of transition: between home and hospital; between sectors; and between individual states

The potential benefits included:

- Home or 'home-like' settings (for residential services)
- Patient centeredness (there was a focus on providing what service users needed rather than what service agencies could provide)
- Increased multi-disciplinary / multi-agency working
- Cost effectiveness (this could be most easily demonstrated in admission avoidance)
- Improved quality of life (as a consequence of residential Intermediate Care)

There were a number of common concerns

- Capacity to deliver a comprehensive service in the long term (limited hours of service availability, limited resources in mainstream services)
- Awareness, perceived efficiency & benefits (although residential models improved individual quality of life they were perceived to be high cost)
- Relatively small number of episodes of care
- Substitute services and additional services (although hospital episodes and length of stay were reduced, Intermediate Care services also provided additional levels of care / support that would not have been provided by existing services)
- More scope for integration with other services
- Variable engagement and involvement of medical staff

There are 3 key areas where we can learn from these evaluations:

- Being very clear about the purpose of intermediate care interventions, so that we maximise the provision of alternative, more appropriate services, and minimise the development of additional new service levels and expectations.
- Ensuring multi-agency, multi-disciplinary commitment to the models of service provision and the transfer of resources from acute to community settings.
- The development of disease/condition specific models that enable smooth pathways for chronic disease management, particularly from acute episodes of care to ongoing self / supported care and independence.

7. Further Work

The JIT have agreed to sponsor a National Seminar where partnerships and organisations can share current practice on Intermediate Care. People not currently involved in the Learning Network can contribute their ideas and experience.

8. Conclusions

The success and effectiveness of Intermediate Care services will depend on the range of existing services, including social work services, the extended primary care team and the role of acute and community hospitals. Across Scotland, a number of people have expressed a strong preference to avoid using the term "Intermediate Care" and have suggested that we consider the term "interface services" i.e. the essential services at the interface between hospital care and ongoing community support, for patients at a time of transition.

Where services report their greatest successes, it is where the interface between intermediate care services and other hospital or community services are well managed.

Common concerns about intermediate care include:

- The absence of a whole systems context for intermediate care
- Project based service development
- Lack of ongoing funding
- Lack of support or information for systematic evaluation, including cost benefit analysis

Recently, the second report from the Range and Capacity Review group[6] identified the need for a range of services to support older people:

"Step up and step down/rehabilitation/intermediate care
We felt that with the increasing numbers of older people, there is a most pressing need for an increase in services that fall within this category.

What we have in mind are services for older people with complex and/or more intensive needs, that are able to respond to rapid changes in the personal needs or frailty of those people. Such services should:

- pro-actively support people living at home so they are not inappropriately admitted to a care home or hospital
- provide intensive rehabilitation prior to returning home
- actively support older people on returning home, and
- facilitate provision of appropriate specialist health support to people in care homes.

Many such services are in place, but they may operate as separate initiatives and not as part of a continuum of care. Examples of such services include:

- intensive care at home, including rapid response and early supported discharge;
- rehabilitation – particularly important in the interface between hospital and home;
- short stays for rehabilitation and respite – often known as intermediate care or step-up/step-down services, and again important between hospital and home."

[6] Range and Capacity Review Group: Second Report: The Future Care of Older People in Scotland, May 2006

Appendix 1.

INTERMEDIATE CARE SERVICES AND DEVELOPMENTS[7]

ABERDEEN

There are 3 specific Intermediate Care services in Aberdeen:

- The Links Unit, a residential facility based at the City Hospital
- Smithfield Court, Intermediate Care within a sheltered housing complex
- Croft House, a residential facility

The services were developed as part of the redesign of continuing care beds and the pressures to enable hospital discharge.

For all services, user satisfaction is monitored through a survey of the Single Shared Assessment, as part of the Local Improvement Targets. An audit of services is being carried out by external consultants and this will provide information on outcomes, cost and benefit and will inform the plans to extend services.

<u>The Links Unit</u>
This is a nurse led facility with GP support provided from the medical practice based on the site. It provides services, primarily (but not exclusively) for the elderly, and offers assessment, investigation and treatment, rehabilitation, palliative and terminal care.

The service is managed and funded by the NHS.

Patients may be referred from the community via their GP, extended primary care team, allied health professional (AHP) or rapid response team; or from other hospitals in Aberdeen (ARI and Woodend).

Services are multi disciplinary and include:
Nursing
Physiotherapy
Occupational therapy
Chiropody
Dietetics
Speech and Language Therapy
Dentistry

The Links Unit does not provide services for:

- patients who require specialised care
- those who have profound confusion, psychiatric or chronic alcohol abuse problems
- people who primarily require social or respite care

Every effort is made to discharge patients back into their own homes, with an appropriate care package and community support. Multidisciplinary assessment is completed with regard to the patients home circumstances and situation.

[7] Contact details for services referred to in this section are provided on JIT website

Smithfield Court
This is a development of 20 fully equipped apartments for older people who require a temporary period of rehabilitation in a community setting. It is based within an existing sheltered housing complex. This is a joint development between the NHS, Aberdeen City Council and Housing. There is a pooled budget for the service which is overseen by Grampian Integrated Care Group.

Smithfield Court provides services for people who are unable to return to, or remain in, their own homes following illness, accident or housing difficulties. This includes:

- people who been discharged from hospital and who need a further period of rehabilitation before returning home;
- people who have had difficulties in their own home and who would benefit from a short period of rehabilitation; and
- people who are considering a move to a care home.

Each resident in Smithfield Court has a personal programme of rehabilitation. Programmes are delivered by a team of physiotherapists, occupational therapists, district nurses and rehabilitation assistants.

Referral can be made by a range of health and social work professionals, including: care managers, social workers, GPs, district nurses, hospital discharge co-ordinators, physiotherapists, occupational therapists and the frail elderly support team. The average length of residence in Smithfield Court is 4 – 8 weeks, although there is flexibility for those who need to stay longer.

Croft House
This is and 8 bedded Rehabilitation and Assessment Pilot Scheme (RAPS). The aim of the services is to reduce unnecessary hospital admission, enable earlier discharge from hospital and delay permanent admission to residential care by enabling older people to remain at home for a long as possible.

There is a maximum 4 weeks stay in the facility and priority is given to delayed discharges or failed discharges.

The service is aimed at Older People who:

- Are physically frail or ill but do not require hospital admission and would benefit from a limited period of rehabilitation in order to regain skills to return home
- Are no longer in need of acute hospital care but need a period of rehabilitation in order to return home
- Have the potential for rehabilitation to enable them to remain in the community and avoid / delay admission to residential care

The service will also cater for people with mental health problems which are not sever or enduring in nature.

Referrals can be made by hospital discharge liaison staff, care managers, social workers, GPs and community nursing staff. Clients receive the support of residential care staff and can receive services from occupational therapists, physiotherapists

and community nurses (available on a sessional basis). Input from a Consultant Geriatrician is also available.

Aberdeen City Council has the lead in managing this service.

ANGUS

Within Angus, a pilot scheme was established in 2001 with 6 Intermediate Care beds being purchased within an existing nursing home facility (The Glens). Following evaluation and consideration of bed usage, there was a decision to purchase only 2 beds from this facility and purchase 6 beds from a nursing home in another locality (Cairnie Lodge). There has been flexibility in being able to commission a variable number of beds in an existing facility and at times an additional place has been made available to assist with winter pressures and aid appropriate and timely discharge from acute services.

Services are provided on the basis of comprehensive assessment and result in a structured care plan that involves active therapy, treatment and opportunities for recovery and rehabilitation. Services have a planned outcome of maximising independence and enabling patients / service users to resume living at home. Services are time limited, normally for no longer than 6 weeks, and frequently as little as 2 weeks.

The aims of the services are as follows:

- To enable a whole systems approach to the patient pathway
- To liaise with coordination staff in Ninewells to target people who would otherwise have unnecessary long stays in hospital
- To prevent inappropriate admission to acute care
- To change the balance of care from acute to community, enabling people to be maintained in their own community
- To ease the transition from hospital to home, and from medical dependency to functional independence
- To provide a time limited multidisciplinary assessment
- To ensure a seamless services across existing early supported discharge and prevention of admission schemes
- To ensure service users have continuing needs for active treatment, therapy and maximisation of independence
- To ensure full involvement of service users and their carers in the rehabilitation process
- To provide short term intervention
- To ensure effective safe discharge (primarily to home)

An expansion of the original criteria has allowed for short-term respite if primary carers are admitted to hospital. This has prevented the inappropriate admission of the cared-for person to an acute hospital.

The use of beds is monitored alongside the use of services including step up, step down, enhanced respite and respite services.

The pilot was evaluated on the basis of:

- cost in comparison to hospital care
- the number of acute bed days saved
- changes in the level of functional ability
- the medical input required
- services user and family / carer satisfaction

A report on the evaluation of the service has been produced by NHS Tayside and Angus Council.[8]

The success of the project is due to effective multi-agency working, with partners being able to consider the risk base when considering admission to the service. A staff evaluation highlighted a number of benefits including:

- more effective joint working
- more seamless care for service users
- an enhanced range of community interventions
- development of staff skills

The use of the Single Shared Assessment has been invaluable as a method of sharing information across disciplines.

During the period of the evaluation (2003/2004) almost half of patients were able to return home with the same, or less need for services. A proportion of the services users did not return home and subsequently waited within the facility until a permanent place was identified.

Service users and relatives reported a high degree of satisfaction with the service. Almost 70% of service users indicated that without the period of intermediate care they would have either been unable to return home, or would have been unable to cope at home. Relatives indicated that the service had reduced the need for hospitalisation or longer-term care.

[8] Independent Intermediate Care. Evaluation Report (2005)

AYRSHIRE

Services in Ayrshire and Arran

NHS Ayrshire and Arran provides services to a population of approximately 370,000 and covers three local authorities: North Ayrshire (139,600), East Ayrshire (120,235) and South Ayrshire (112, 097). From April 2006 there were be three Community Health and Care Partnerships (CHCPs) and these partnerships are already exerting a strong influence, ensuring that health and social care plans reflects the needs of local communities. The number of people in Ayrshire and Arran aged over 65 has been increasing and is predicted to reach 65,000 in 2006. Between 2000 and 2010 a 10.4% increase is predicted which is above the Scottish average of 6.8%, with the highest percentage increase in North Ayrshire[9]. Older people use health and social services more frequently and this means that a greater proportion of funding will be required to meet their needs. Information from 2003 showed that combined health and local authority spending on older people's services in Ayrshire and Arran was in excess of £80 million per annum.

In addition to the provision of mainland services, health and social care is also provided to the islands of Arran and Cumbrae. In Arran the resident population is around 4,500 and this is increased significantly over the summer months by the influx of holidaymakers. There are particular issues to be considered in the provision of services to an island community, including transport links, rurality and the need for integrated service provision.

Management of delayed discharges is the subject of a national CITISTAT pilot programme, supported by the Scottish Executive and involving the three local authorities and NHS Ayrshire and Arran. This is informing service redesign and discharge planning from acute services.

Overview of Intermediate Care in Ayrshire and Arran

There are currently four specific residential facilities in Ayrshire that provide designated intermediate care services – three have developed as social care models with health input : *Up and About* at Templeton House, Ayr (7 beds South) ; *David White Unit*, Saltcoats (10 beds North); *Ross Court*, Galston (10 beds East) with the fourth being NHS managed - *Kirklandside* Hospital, Kilmarnock (16 beds East and North). In addition planning is underway for a further intermediate care facility in North Ayrshire that will also provide specialised intermediate care services for people with dementia, and the proposals for the new community hospital in Girvan include a number of rehabilitation / intermediate care beds. There are a range of services that provide services that support and enable intermediate care including community hospitals; Rapid Response Service; hospital discharge services, integrated care teams, home care services and many others, including the range of day care/day hospital service.

<u>Up and About</u>
This service is based in Ayr and is collocated with a residential and respite unit for older adults. The service offers short residential programmes of therapy and

[9] Ayrshire and Arran Strategy for Older People - 2003

rehabilitation to people over the age of 60 who are medically stable and who require a period of support before going home. Residents follow an individually designed programme for a period of up to 6 weeks.

There are 8 staff including:

- Physiotherapy
- Occupational Therapy
- Social care workers

During their stay, clients remain under the care of their own GP.

Referrals to the service can be made by hospital staff, GPs, district nurses and social workers.

During 2005/06, services were provided to 48 people, of whom 81% were over the age of 75. Most people (68%) received services for less than 4 weeks although a small number (10%) remained for 7-8 weeks. On average the EMS score increased from 12 to 17.5 between admission and discharge reflecting the high level of rehabilitation input and the consequent increased ability to be independently mobile. 87% of patients were discharged home with a small overall increase in the requirement for support at home.

Evaluation in 2005/06 showed that 100% of services users considered their discharge to be successful.

<u>David White Unit</u>
The David White Intermediate Care Unit was established against a background of demographic change including an increasing number of older people (above the Scottish average). The Intermediate Care Unit was opened in August 2005 to provide intensive support and rehabilitation for people who whose independence would be improved within a 6 - 8 week timescale. The unit can accommodate up to 10 residents. It is managed by North Ayrshire Council and is staffed by a range of professionals with health and social care backgrounds.

The Unit operates within a tightly defined set of criteria that govern the admission, support and discharge of residents. Referrals are made from acute and community hospitals (post surgery, post fracture, post infection etc) or from services in the community (district nurse, community care team, GP etc). There are good relationships with other local service providers including hospitals, GP, health centre staff and social work staff. There has been wide communication about the David White Unit through presentations at meetings and opportunities for colleagues to visit the Unit. The purpose of the Unit, its potential benefits and the admission criteria are becoming widely understood.

The majority of the funding for the David White Unit is from North Ayrshire Council, although there is additional funding for the physiotherapy post from the winter pressure funding available to NHS Ayrshire and Arran NHS and GP cover for the unit is provided by NHS Ayrshire and Arran.

<u>Evaluation of the Unit</u>

The focus for evaluation of the service in the David White Unit is one of the aims of the project: i.e. the improvement in independence of patients/clients/residents within a 6 - 8 week timescale. The information collected supports this evaluation, and the evaluation of associated aspects, for example, adherence to the admission criteria, outcomes, length of stay, changes in levels of independence (based on individual care plans and agreed personal goals).

The evaluation collects information on the levels of Home Care support prior to admission and following discharge. This element is considered in more detail than other aspects of care, for example day care services or district nurse support.

In addition to information for management and operational analysis,
data is collected regarding the quality of care and the level of patient/client satisfaction. Thus identifies levels of satisfaction with care staff, the facilities and support services, staff involved in an individual's care, and the sense of respect and dignity.

The evaluation currently includes information about service users in the two weeks following discharge from the David White Unit.

The Unit also collects and analyses information in relation to key risks for the successful operation of the Unit e.g. inappropriate admissions or lack of availability of suitable placements.

Within North Ayrshire, the David White Unit has good access to the joint equipment store. It is perceived that there is a good response to requests for aids and equipment that would support and enable independent living. The current evaluation process records the identified need for aids and equipment but does not yet record the time for these to be available and the potential impact on discharge of residents.

Ross Court
Ross Court Resource Centre in Galston is a recently opened facility providing a wide range of facilities and services for older people which aim to support them to remain independent in their community. The services include lunch clubs, information and advice, day services and a short-term assessment and rehabilitation facility.

The services are provided in a pleasant and homely environment by appropriately trained staff.

East Ayrshire Social work department is working with partner organisations to develop quality and flexible services for older people which meet their needs and which enable them to stay in their own homes. The resource centre operates on a partnership basis with all social care and health service providers in the area including:

- GPs
- District Nurses
- Pharmacist
- Dentist
- Home Carers
- Social Work Services

- Community groups.

The Resource Centre has wide inclusion criteria for residential admission. Although there is a focus on rehabilitation, Ross Court will accept people who would benefit from a further period of assessment to maximise the opportunities for them to remain in their own homes as an alternative to permanent residential care.

Kirklandside

Kirklandside is based in Kilmarnock and has 16 beds. It currently offers a step down service to speed up discharge from hospital easing the transition back home, promoting independence and preventing unnecessary stays in hospital. Patients are from East Ayrshire and North Ayrshire.

The service is time limited for a maximum of 8 weeks.

Services are for people over the age of 60 who have health and social care need which require intervention and support to enable an increased level of independence. Patients must be medically stable, no longer requiring the service of an acute hospital, and have a realistic chance of rehabilitation (based on a multi-disciplinary assessment). The unit does not cater for people who have multi-infarct dementia or Alzheimer's disease.

People who benefit from the services in Kirklandside include:

- people who have previously received care in acute hospital for urinary tract infection(UTI), chest infection etc and who require further rehabilitation
- people who have been admitted to hospital due to a physical disability or illness and who will require rehabilitation to return to their previous level of independence
- people discharged from orthopaedic services requiring further rehabilitation
- older people who require inputs beyond those provided by the primary care team, but who do not need the services of an acute hospital.

There is a multi-disciplinary team that includes input from :

- Discharge co-ordinator
- Rapid response services
- GP
- Nursing staff
- Physiotherapy
- occupational therapist
- Speech and language therapy
- Dietician
- Social worker
- Home care manager
- Liason health visitor
- Community nursing staff

Medical cover to the service is provided by the local GP practice and admission is restricted to 9am - 4pm Monday to Thursday and 9am - 1pm on Friday.

Benefits to patients include:

- Earlier discharge from hospital
- Extended discharge planning
- Extended rehabilitation
- Increased recovery and regaining independence

Between 2002 and 2006 the service has provided care for more than 500 people, the majority of whom (52%) have had fractures or dislocations. Although patients ranged in aged from 52 to 100, the average age over 75. The average length of stay is around 28 days.

EAST RENFREWSHIRE

East Renfrewshire is located to the south of the City of Glasgow . It covers an area of approximately 67 square miles (174 square kilometres) and is one of the smallest Local Authority areas in Scotland, with an population of around 90,000.

There are only limited areas of disadvantage in East Renfrewshire and some fairly wealthy neighbourhoods. Crime rates are below average. The Council does, however, have to deal with a range of local needs which are affected by population change and a predicted increase in the population of older people, which is twice the Scottish average. It has been able to invest in early intervention and this is paying off. Because of this, and because of its close working with the voluntary sector, the Council provides a good range of high-quality social work services.

There are 2 teams providing Intermediate Care in East Renfrewshire. In Eastwood a range of services have been provided for 5 years to a population of 55,000. This is an extended community model which focuses on the prevention of admission, assessment and active rehabilitation. It may include services for people with complex discharge requirements.

There is good interaction with the Royal Alexandra hospital and where possible relevant patient information is shared one week before admission or discharge to enable smooth planning and delivery of care.

In Leven Valley, a team provides Intermediate Care services to a population of 24,000, including more than 6,000 older people. This team is responsible for the rapid assessment and rehabilitation of frail older people. It aims to prevent admission to hospital. The team also tracks individuals through their hospital stay and enables early complex discharge.

The services are patient centred, ensuring that resources and services are available to meet individual need, including physiotherapy, occupational therapy and community psychiatric nursing.

The services are successful because there is a good juxtaposition between health and social care. There is good agreement and understanding between the agencies involved in the services, and importantly, there is charismatic leadership of the team. There is a high level of job satisfaction with staff being members of the team, yet maintaining close contact and support from others in their own profession. Having dedicated teams has enabled the focus to be maintained on the aims of the service (preventing admission, supporting early discharge and enabling independence) and efforts are not dissipated by other service pressure in the area.

The development of intermediate care services may have had an impact on home care, increasing the requirement for services if people are supported who might otherwise have moved to long term residential care. This has increased pressure on home care budgets. In the early phases of the service, most service users were passed on to home care following completion of their intermediate care service, however this process is now more targeted. Although there are some people who required an increase in there ongoing care package, there are also people who as a consequence of the intensive rehabilitation process, have reduced requirements for care and support.

Evaluation of the services has demonstrated significant improvement short term improvement in independence and mobility although this has not been monitored over a longer period.

The intermediate care services in East Renfrewshire do not have residential facilities. People are admitted to hospital for complex investigations, and respite care and some rehabilitation is provided in residential nursing homes.

There is scope for further development of intermediate care services including services for people with dementia and the provision of very sheltered housing.

Services have been funded substantially through resource transfer enabling a shift in the balance of care from acute to community services. It is recognised that any further developments of the service would require disinvestment in another area of care to enable resources to be transferred. It is important the intermediate care services are included in strategic planning processes to ensure that funding is prioritised towards the most effective care.

GLASGOW

Greater Glasgow Integrated Discharge Management

Aims and Objectives

- Provide a whole systems approach to discharge management for all patient groups within Glasgow acute hospitals.
- The integrated structure ensures smooth and seamless patient journeys, minimising gaps and delays and providing clarity of roles within the single team framework.
- Improving and monitoring performance across the raft of discharge activity.
- Providing appropriate admissions avoidance, early and supported discharge services, particularly to older people.

History

- Integrated discharge management was established in 2004
- IRIS - Interdisciplinary Response & Intervention Service - which provides appropriate admission avoidance and early supported discharge was established in 2002.
- DART - Discharge and Rehabilitation Team established in 2003
- OHPAT - Out Patient and Home Parental Antibiotic Therapy Service established in 2001
- Acute Hospital Homeless Liaison Service established in 2004

The initiatives were developed through the Joint Planning processes involving health and local authorities.

Potential Benefits

- IRIS provides appropriate admission avoidance by GP rapid response, discharge from A&E.
- IRIS & DART provide early supported discharge from in-patient areas targeting vulnerable older people.
- Delayed discharge numbers reduced after the establishment of the service.
- OHPAT provides an alternative to in patient care for patients requiring intravenous antibiotic therapy and has a significant impact on the length of stay for patients included.
- Acute hospital homeless liaison service provides a structured link back to the community services for homeless people attending or being admitted to hospital.

Technology

- A joint integrated care pathway is utilised within IRIS and a database has been set up to report jointly on health and local authority information for ISD.

- IRIS & DART staff can order equipment from GGILES - Greater Glasgow Independent Living Store website.

Results

IRIS admission avoidance from April 2005 to March 2006 - 533

Supported discharge from April 2005 to March 2006 - 2,050

DART early supported discharge from April 2005 to March 2006 - 765

OHPAT April 2005 to March 2006, total patients referred - 404

- 306 patients referred for IV antibiotics, of these 289 were included
- 98 patients referred for IV access
- Total avoided admissions - 135
- Total bed days saved - 4,196
- Total bed days saved since 2001 - 19,112

LANARKSHIRE

Managed Care Network in Lanarkshire
JIT is supporting the development of a Managed Care Network (MCN) model with North and South Lanarkshire Health and Social Care Partnerships. This model will allow older people better access to health and social care services across acute and community settings, including housing, transport and services provided by voluntary organisations. The Managed Care Network model will help deliver better outcomes for older people in Lanarkshire in line with local and national priorities and targets. Specifically, it aims to:

- Develop a framework to support integrated single system working for older people's services across acute and community settings;
- Help Partnership groups in Lanarkshire to integrate health and social care across organisational boundaries;
- Deliver a Lanarkshire-wide joint strategy, action plan and financial framework for older people's services in line with emerging national strategy for older people;
- Enrich users and carers' experience, improve quality and deliver better outcomes through developing staff roles, skills and competencies; and
- Help NHS Lanarkshire and its partners to meet Local Delivery Plans and Local Improvement Targets.

Whilst this work has a much braoder focus, intermediate care services will be included in this network of care. Further information on the development of the MCN is available on the JIT website.

In addition, work is under way in Lanarkshire to develop **a Multi-professional Competency Framework to support Intermediate Care**

Lanarkshire has secured support from NES to:

- develop and implement a multi-professional and interagency competency framework to support practitioners working with frail older people in multidisciplinary health and social care teams across acute and community settings.
- evaluate the utility and educational impact of the interdisciplinary and multi-agency learning model and assess service impact and user and carer experience.
- build workforce capacity within evolving Community Health Partnerships to enhance local services designed to meet Delivering for Health targets for Shifting the Balance of care, reducing Delayed discharge and managing Long Term Conditions.

The outcome of this work will be an externally validated multidisciplinary competency framework for interagency staff working with frail older people across a range of intermediate care settings. The framework will adopt a novice to expert approach (b*ased on the Benner model*[10]) to support staff working at all levels, from untrained to the more expert practitioner working with greater autonomy.

[10] Benner, P (1984) From Novice to Expert: Uncovering the Knowledge Embedded in Clinical Practice. Addison- Wesley. California

An independent evaluation undertaken by a higher education institution partner will establish the utility and educational impact of the competency framework, explore the opportunities and collaborative advantages of an interdisciplinary and multi-agency learning programme, and evaluate the service impact through qualitative assessment of staff and of patient and carer experience of the health and social care journey.

The model will support continuous professional development and will empower nursing, AHP, medical, pharmacy and social care practitioners to develop competencies in care for frail older people. The intermediate care competencies developed will incorporate a generic approach to managing long term conditions, promoting self care, improving health and managing medicines and will complement the emerging NES Care management competency framework and education. They will also take cognisance of the emerging MINTS (Minor/Major Injuries/Illness Nurse Treatment Service) competencies being developed through the unscheduled care collaborative.

Evaluation will be qualitative and will be based on Questionnaires, individual interviews and Focus groups of staff (trained and untrained nurse and AHP staff from acute and community settings across a range of professions, social work staff, pharmacists, paramedics, homecare and care home staff).
Service impact will include patient and carer experience as assessed from patient experience narratives obtained through focus groups.

Competency framework content will be reviewed by MCN Stakeholder forum and by the Patient & Carer Reference group to ensure that all relevant areas have been incorporated into the document. Patients & Carers will contribute to the development and evaluation of the Framework through participation in focus groups and feedback through a Patient & Carer Reference Group. This group will include representatives from voluntary sector, Lanarkshire Seniors forum and Better Government for Older People groups.

Project Plan

Learning needs analysis with CHP teams:	by Aug 06
Develop competency framework and education programme:	by Dec 06
Pilot programme in multi- professional group:	Jan – Apr 07
Evaluation:	May – Aug 07 (and ongoing)
Roll out across CHPs:	Aug 07 – Mar 2010
National Dissemination:	from Aug 07

LOTHIAN

The City of Edinburgh Council and NHS Lothian Health and Social Care Department are reviewing their intermediate care services and doing this within the context of an overall review of service provision. There are a range of services that prevent unnecessary admission to hospital and support discharge from hospital and the review specifically considers:

- Community Rehabilitation
- Crisis Care (including Trial Discharge)
- Rapid Response

The review of the intermediate care service came about as the group of services falling into this category had developed as individual services without there being any overall strategic leadership or review of the collective work being done in line with organisational goals. Work commenced on the review in January with the subsequent appointment of a Review Lead Officer in June 2006.

A large reference group is available to the review including representatives from each of the services being reviewed, stakeholder services with the Department of Health and Social Care (including home based care and the practice teams), primary care teams (including district nursing) and key stakeholders within NHS Lothian (unscheduled care collaborative, MOE and combined assessment unit).

The review included 4 key elements:

1) Information Analysis and Comprehensive Monitoring Exercise

- 6 months service data has been collected from January – July 2006. There were initial concerns with regard to the quality of the data requiring the exercise to be extended from the 3 months originally intended
- Full analysis of the data will take place by Research and Information once outstanding work on referrals included to end July has been completed.
- Staffing establishment
- Budget Information

2) Intermediate Care Process Mapping Workshop

In order to develop a better understanding of the pathway of options and services available a Process Mapping Workshop was held involving a range of health and social care staff from community and hospital services.

Participants considered 3 scenarios involving an elderly lady who suffered a fall:

- Patient with fractured hip admitted to hospital
- Patient assessed in hospital – fractured humerus that does not require admission
- No injury sustained, patient maintained at home

The current possible journeys of service users through the available services were mapped, and problems, gaps in services or duplications were identified. Participants considered the ways in which services might be changed to make the process less complex, to address issues and problems and to enable equity of service provision for people across Edinburgh. Key recommendations were considered by a group of managers and an action plan developed to take these forward.

There were 5 main areas where concerns were identified: the use and sharing of information; the consistency of service provision; the flexibility of service delivery; the effective use of existing staff resources; and support for carers and families.

- Information
  - Sharing information between professions
  - Access to IT systems
  - Patient held record

- Consistency
  - At different times
  - Across the City
  - Across Lothian

- Flexibility
  - Between services
  - Use of staff

- Clarity about Roles/Streamlined Processes
  - Access to equipment
  - Key worker
  - Single point of contact

- Support for families and carers

There were several areas where changes could be made that would streamline the provision of services, improve access to required information and increase equity of services provision.

- Training for care workers to recognise and report confusion
- Identification of high risk patients in the community
- Access to therapists, occupational therapists, on an equitable basis
- Collaborative occupational therapy services
- Central crisis / response team (24/7/365)
- Earlier transition to mainstream services
- Clarification of terminology (i.e. what are *mainstream* services)
- Appropriate management location for trial discharge service
- Improved transfer of information to A&E e.g. information about long term conditions, existing care
- Care worker to support person going home from A&E (24hr)
- Early SW input during hospital stay
- Early access to support systems (equipment, alarms)
- Key worker to facilitate discharge
- Condition / group specific discharge pathways (stroke, neuro, COPD)

Service managers have been meeting to develop robust action plans. This includes further development of detailed patient pathways within Community Rehabilitation, Crisis Care and Rapid Response services.

A series of process mapping workshops had already undertaken around the Geriatric Orthopaedic Rehabilitation Unit (GORU) services in North and South Edinburgh and ward 203 (rehabilitation ward) in the Edinburgh Royal Informary (ERI). In order to link with the ongoing review of GORU services, the process mapping was based on

scenarios that included orthopaedic trauma. This will provide a useful overview of inpatient and community pathways and inform further work and potential service redesign in this area.

Further consultation is also being carried out with Combined Assessment and A&E services in Edinburgh, since these were determined to be key points in enabling smooth pathways of care. Proposals for change will be considered within the context of an overall review of service provision in Edinburgh.

3) Focus groups

Seven focus groups have been identified from list of stakeholders with assistance from Research and Information and Reference Group. The groups are: Members of staff from each service, Referrers from Health and Social Work and service users. Service users will be consulted via a semi-structured telephone interview. Other independent stakeholders will be consulted via questionnaires or semi-structured telephone interview. The groups will provide information on the services function as well as information to review the role, structure and management resources available to the teams

4) Benchmarking

Work is ongoing within Performance Management to assist in benchmarking the services provided within Intermediate Care against other similar services