

Intermediate Care Services

A Toolkit for Planning

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

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

Components of Intermediate Care Services in Scotland

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

Toolkit for Planning

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

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

The self assessment toolkit is arranged in 4 sections:

- Service Purpose *page 2*
- Organisation and Delivery of Intermediate Care services *page 3 - 7*
- Management of Intermediate Care services *page 8 - 9*
- Evaluation *page 10 - 11*

How to use this Toolkit

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

collective understanding and will illuminate areas where there is lack of clarity and a need for further consideration.

SECTION ONE: PURPOSE

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

Purpose of the Service

Key Questions :

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

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

Other				
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SECTION TWO: ORGANISATION AND DELIVERY

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

Range of Settings for Service delivery

Key Questions:

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

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

Accessing the Service

Key Questions:

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

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

Who can refer ?

Key Questions:

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

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

Caseload / Client Group

Key Questions:

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

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

Staffing

Key Questions:

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

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

SECTION THREE: MANAGEMENT

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

Service Funding Stream(s)

Key Questions:

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

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

Communication with Other Services

Key Questions:

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

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

SECTION FOUR: EVALUATION

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

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

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

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

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

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

Evaluation of Intermediate Care Service

Key Questions:

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

Information / Data	Prospectively captured	Easily accessed retrospective	Occasionally accessed or with difficulty	Currently not able to be measured
Referral rate / sources				
Level of unmet need				
Adherence to protocols				
Monitoring of individual care plans				

Duration of intervention				
Nature of intervention				
Baseline mobility, independence and function				
Mobility, independence and function at discharge from IC				
Destination at transfer from service				
Patient / client experience				
Change in need for ongoing support				
Longer term outcome and support needs				
Comparatives outcome analysis				
Bed days utilisation				
Readmissions				
Cost benefit analysis				
Impact on Carers				
Other				