

Intermediate Care Services

Definitions of Intermediate Care

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

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

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

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

Intermediate Care Services in Anyarea*

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

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

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

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

Who was involved in completing this matrix:

NHS Head of Community Planning

Director of CHP 1

Assistant Director CHP2

Manager IC service A

Manager IC service B & F

Manager of hospital X rapid response team

Director of Rehabilitation and AHP

Team Leader IC service D

Assistant Director of Social Work, Head of Adult Services

Overall Purpose / Outcomes

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

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

Range of Settings

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

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

Accessing Intermediate Care Services

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

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

Referral source

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

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

Client group

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

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

Staffing

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

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

Links with other services

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

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

Funding

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

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

Evaluation

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

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