



**Provision of Intermediate Care for Older People in Fife:
A Needs Assessment**

FINAL REPORT

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Table of contents

1	Executive Summary.....	ii
1	Introduction.....	1
2	Background.....	1
3	Aims.....	2
4	Objectives.....	2
5	Methods.....	3
6	Findings.....	6
6.1	Literature review on models of intermediate care.....	6
6.1.1	Key findings from literature review.....	19
6.2	Findings from qualitative interviews.....	20
6.2.1	Definitions of intermediate care.....	21
6.2.2	Models of intermediate care in Fife.....	21
6.2.3	Patient journey.....	23
6.2.4	Decision making processes.....	24
6.2.5	Eligibility criteria for intermediate care services.....	25
6.2.6	Joint working.....	26
6.2.7	Risk aversion.....	27
6.2.8	Accessing services.....	27
6.2.9	Home Care services.....	28
6.2.10	Telecare provision.....	29
6.2.11	Impact of geographical characteristics of Fife region.....	29
6.2.12	Changing demographics.....	30
6.2.12	What do older people in Fife think about intermediate care service provision?.....	30
6.2.13	Improving intermediate care services in Fife.....	32
6.2.14	Current developments in intermediate care in Fife.....	34
6.2.15	Key findings from qualitative interviews.....	35
6.3	Quantitative analysis.....	37
6.3.1	Demography.....	37
6.3.2	Emergency admissions of older people to hospital in Fife	38
6.3.3	Analysis of local data.....	39
6.3.4	Key findings from quantitative analysis.....	48
7	Discussion.....	49

8	Recommendations.....	53
9	Acknowledgements.....	54
10	Appendices.....	55
11	References.....	67
Provision of Intermediate Care Services for Older People in Fife: A Needs Assessment		

Executive Summary

Introduction

Concerns around the levels of delayed discharges led to a desire to investigate the full range of intermediate care models currently being provided in Fife.

This needs assessment therefore reports on the background to and definitions of services that can be classed as part of an intermediate care “function” in Fife. This is provided alongside evidence from the available literature, interviews with a wide range of stakeholders and local and national data to illustrate some of the current services providing an intermediate care function in Fife.

It aims to arrive at findings that will help Fife partners to decide if the current range of services is well suited to the population needs, or that some service developments and changes should be taken forward.

Key findings from literature review

- Intermediate care has been a key focus of health and social care policy in England for several years and many different models of intermediate care have developed in response to this. In Scotland, intermediate care as a concept is not a key driver in health and social care policy although key publications mention intermediate care initiatives as being an important aspect of adult rehabilitation services.
- There are many different definitions of intermediate care in the published literature. The recurring theme is the role intermediate care services play in providing support to prevent unnecessary admissions to and discharge from a hospital setting.
- The British Geriatrics Society identified the key points in a patient’s journey where intermediate care might be of most benefit as:
 - Managing crises in the community and at home
 - Managing crises “at the front door” i.e. when patients first present to an acute hospital setting
 - Managing the post-acute phase
- There are many different models of intermediate care, the majority concerned with providing support for discharge from hospital. These models differed according to the location of the care being provided (e.g. patient’s home,

hospital ward, residential care home), the team providing the care (e.g. hospital at home team, rapid response team, intermediate care team) or whether a specific condition was being cared for (e.g. falls response, mental health liaison).

- Evaluation of intermediate care initiatives varied widely and there was an overall lack of evidence around cost effectiveness of the various models. Simple data describing intermediate care services was often not collected.
- A national evaluation of intermediate care services for older people in England highlighted some key learning points around the challenges of intermediate care including:
 - The importance of effective partnership working between health and social services organisations,
 - Intermediate care services not being used to their full potential or being used inappropriately at times due to lack of awareness, resistance, concerns about effectiveness and the inability of intermediate care services to always respond positively to referrals,
 - The intermediate care label was being used to describe services that pre-dated the official guidance and some conventional services (community hospitals, domiciliary care, community rehabilitation) have been relabelled as 'intermediate care'.
 - This diversity in provision was felt to become problematic when trying to evaluate intermediate care and gather evidence for its effectiveness. A systematic literature review carried out by the evaluation team identified relatively little evidence on the effectiveness or cost-effectiveness of admission avoidance services. However, case-studies and process modelling undertaken as part of the evaluation identified the following:
 - Residential intermediate care services have a higher cost than non-residential services, and admission avoidance schemes have a lower cost than supported discharge services.
 - The largest gains in quality of life were seen for residential services (compared to non-residential) and for admission avoidance schemes (compared to supported discharge).
- Based on the above findings, the authors reported that the results provided strong support for a focus of resources more on admission avoidance intermediate care services as opposed to supported discharge services.

Key findings from the qualitative interviews

- Intermediate care was broadly defined as covering the ranges of services in place to prevent unnecessary admission to hospital or support discharge from hospital. Further discussion around what services or teams should be classed as providing intermediate care would be beneficial.
- There are many different teams throughout Fife providing support to people being discharged from hospital and, to a lesser extent, providing support to prevent unnecessary admission to hospital. These include Integrated

Response Teams, Community Rehabilitation Teams and Rapid Assessment & Discharge Teams. The Fife Falls Response Service also plays a key role in preventing unnecessary admission to hospital. There may be overlaps in the services provided by these teams.

- The decision to discharge an older person is undertaken following a multi-disciplinary assessment to determine that person's potential for rehabilitation. Issues raised around this process included social work input and acceptance by families of the decision that had been made. The timescale of this work did not allow the experiences of an older person who had been through this process to be explored further.
- People affected by dementia make up a considerable proportion of the clients seen by teams and services providing support to prevent unnecessary admission and support discharge from hospital.
- Joint working between health and social care services was seen as being key to providing effective intermediate care. Team composition differed depending on the main function of that team. Joint working between acute and community based health care staff was also noted as being important to providing effective intermediate care.
- There were some concerns raised that staff are too "risk averse" and tend to err on the side of caution when deciding when a patient was fit to move to the next stage of their journey.
- It was suggested that a more coordinated approach to the various teams providing intermediate care might be beneficial. Concerns around this included having to refer via one point of access and providing such a service on a 24hr basis.
- There were differences of opinion around using residential or nursing home beds to provide intermediate care.
- Accessing home care services was felt to be an issue by some interviewees and this could impact on the role of rehabilitation care assistants provided via integrated response teams.
- Telecare can provide important support to help older people remain in their home.
- Older people in Fife, via the Fife User Panels and Fife Elderly Forum, felt that the model of intermediate care should reflect the needs of the individual. It was highlighted that some people may need nursing care whilst others function better at home. It was also highlighted that remaining in hospital too long had a negative impact on a person's confidence level which did not help in the long term.
- Several ways of improving intermediate care services in Fife were provided including overall coordination of all intermediate care services through one agency, establishing dedicated intermediate care teams or facilities and continuing to promote joint working between appropriate stakeholders.
- Several intermediate care initiatives have been progressed including joint working between different teams, expanding existing teams, proposals to develop key roles such as A&E based Home Care Managers.

Key findings from the quantitative analysis

- The population of people aged 65 and over in Fife is projected to increase from 59840 in 2006 to 83850 in 2021 – an increase of 40.1%.
- In particular, the number of males aged 85 and over is projected to increase by approximately 115% from 2027 in 2006 to 4365 in 2021.
- If current rates of admission of older people to hospital are applied to population projections, there is the potential for 9055 people aged 65 and over to be admitted to hospital as an emergency in 2021 – an increase of 2593 compared to 2006.
- The increase in the number of people aged 65 and over in Fife in coming years, and the potential increase in the number of emergency admissions to hospital, has significant implications for service provision in Fife.
- Local data showed that there are a variety of teams in Fife providing support to people being discharged from hospital. To a much lesser extent, these teams provide support in order to prevent admission to hospital.
- The majority of clients currently being referred to these services are female and aged 75 and over. Given the high rate of emergency admissions for males aged 85 and over in Fife, alongside the projected increase in this age group, it would be useful to explore the reasons for this difference. For example, it may be partly related to women's life expectancy being greater than men's and therefore being more likely than men to be living alone. Consideration should be given to ensuring that males aged 85 and over have appropriate access to these services according to need.
- The majority of referrals to community teams come from physiotherapy staff, occupational therapy staff, GPs and Fife Falls Response Service.
- The majority of main diagnoses for people referred to community teams are medical, neurological, mobility, orthopaedics and falls.
- The majority of referrals through the Point of Access for Community Teams (PACT) and Single Point of Access (SPOA) services are for Community Rehabilitation Teams, Integrated Response Teams and Community Physiotherapy Teams.
- In the Glenrothes & North East Fife area, more than 30% of people referred via the SPOA service will be referred more than once. In some instances, there have been people referred up to ten times, often for similar services.
- The majority of referrals to Integrated Response Teams in Dunfermline/West Fife and Central Fife come from hospital staff which reflects the fact that the majority of referrals are to support discharge.

Key recommendations

The recommendations from this needs assessment are as follows:

- Intermediate care can be provided by a variety of services including health, social care and housing. All further dialogue around intermediate care in Fife should be undertaken in partnership with representatives from each of the appropriate services and stakeholder groups. The views of older people in Fife should also be taken into account.
- For the purpose of this needs assessment, the concepts of “preventing unnecessary admissions to hospital” and “supporting discharge from hospital” were used to broadly define intermediate care. It is recommended that the Older Peoples SIG uses these concepts as the basis for developing a Fife wide definition of intermediate care at a strategic level.
- The strategic definition of intermediate care should be used at a local level to provide guidance in undertaking a full mapping of local services currently providing intermediate care.
- Given the evidence around the potential benefits for patients (improved quality of life, maintaining confidence) and for services (less demand on beds, lower costs), more emphasis should be placed on developing initiatives that support the prevention of unnecessary admission to hospital. Discussion around what constitutes an appropriate geriatric assessment should be part of this work.
- It is recommended that a core dataset of key indicators is collected by each team providing intermediate care. This would allow meaningful analysis to be carried out to provide valuable information on the services provided by the teams and the needs of the service users.
- Given the number of different teams across Fife providing potentially similar services, consideration should be given to a more coordinated approach at a local level, possibly developing the PACT and SPOA model to include a clinical coordinator role to ensure referrals were appropriately routed.
- Further dialogue around the role intermediate care services can play in ensuring timely discharge from hospital is needed in order to maximise potential benefit.
- Links with local and national projects looking into the experience of older people when being discharged from hospital should be established/maintained in order to ensure learning points are shared.
- Further consideration should be given to the role of the independent care sector and housing can play in intermediate care services in Fife.
- Links should be maintained with the Intermediate Care Learning Network, facilitated by the Joint Improvement Team, in order to learn from the experiences of other areas in developing intermediate care services.

Provision of Intermediate Care Services for Older People in Fife: A Needs Assessment

1 Introduction

Concerns around the levels of delayed discharges led to a desire to investigate the full range of intermediate care models currently being provided in Fife. At an initial meeting in August 2007, attended by a broad range of stakeholders, there were a wide range of views about the issues. It was therefore agreed by all parties that further investigation was the next step.

This needs assessment must also be seen in a wider context of: the Rehabilitation Framework; the Management of Long term conditions; the work Local Management Units have been progressing, as well as delayed discharges and capacity planning.

The work explores the background to, and definitions of, services that can be classed as part of an intermediate care “function” in Fife, alongside evidence from the available literature, interviews with a wide range of stakeholders, set alongside the range of current services in Fife. It aims to arrive at findings that will help Fife partners to decide if the current range of services is well suited to the population needs, or that some service developments and changes should be taken forward.

2 Background

Current quality standards in the NHS classify a person as having a “delayed discharge” if there is a time period of more than six weeks from the date when they were classed as “medically fit for discharge” and their actual date of discharge. Given this target, there can be an emphasis on moving people through the various stages of their journey of care quickly and procedures often mean that people are assessed following a serious health crisis and decisions can be made quickly regarding their future care.

Recent evidence from a digital stories project involving the Joint Improvement Team (JIT) and NHS Scotland Information Services Division¹ suggested that many older people do not really understand nor feel involved in the decisions that can be made at a time when they are particularly vulnerable. This can happen either in an acute hospital setting when an older person has been deemed medically fit for discharge but requires additional support to allow them to return home or, alternatively, in a community setting where an older person requires additional support to allow them to remain in their own homes thus preventing an avoidable admission to acute care.

The opportunity for the older person to have time to think through their options and to psychologically adjust to what may be a major change in their life circumstances is vital. Ideally, the preferred process would be to allow

people to have time to make decisions about their future care either at home or in an appropriate homely setting.

With regards to discharge from an acute setting, multi-disciplinary assessment of the individual's capabilities, preferences and choices is key to this process and should ensure that every opportunity is used to enable the person to return home, if possible.

In community settings, older people should have access, where appropriate, to similar opportunities to support them in a timely fashion to prevent avoidable admissions to hospital.

Such services can be classed as a form of "intermediate care" which has been defined 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 or "a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living"³. Many of these services may also come under the general term of rehabilitation⁴.

An appropriate model of intermediate care in the NHS Fife region could provide opportunities to assist in preventing avoidable admissions of older people to hospital and facilitate re-enabling those being discharged from hospital to return home where appropriate.

3 Aims

To investigate models of intermediate care which enable appropriate multi-disciplinary assessment to take place and facilitate a more user-friendly opportunity for decision making for the older person.

To assess the appropriateness of adopting particular models of intermediate care in Fife to support appropriate discharge from hospital or prevent avoidable admission to acute hospital settings.

4 Objectives

Objective 1: To review the evidence base for the effectiveness of different models of intermediate care that facilitate timeous hospital discharge as well as admission prevention as required.

Objective 2: To understand how current service provision in Fife, effectively or otherwise, supports timeous discharge of the older person from hospital.

Objective 3: To understand how current service provision in Fife, effectively or otherwise, supports the prevention of avoidable admission of the older person to acute hospital settings.

Objective 4: To consider the extent to which current decision making processes and time constraints in hospital result in older people moving into appropriate care settings or otherwise.

Objective 5: To consider the extent to which current decision making processes and time constraints in the community setting facilitate the prevention of avoidable admission of older people to an acute hospital setting or otherwise.

5 Methods

The following methods were used to inform this needs assessment:

Literature Review

A review of published and grey literature was undertaken to provide background knowledge to the different existing models of intermediate care and their relevance to the Fife scenario.

Ageline, CINAHL, Embase and Medline publication databases were searched for articles containing the phrase “intermediate care” in either the article title or abstract. A total of 152 abstracts were reviewed with relevant articles being identified for further consideration.

The internet was also used to identify sources of grey literature i.e. published non-academic reports around intermediate care. Several key reports and publications were identified using this method.

Qualitative interviews with key stakeholders

Key stakeholders involved in intermediate care services throughout Fife were asked to participate in a qualitative fact finding interview to establish current decision making processes and services available in Fife to support the prevention of older people being admitted to hospital unnecessarily and support older people being discharged from hospital in a timely fashion.

A total of 23 individual qualitative interviews were carried out with key stakeholders including consultant geriatricians, discharge coordinators, social work team leaders, health care team leaders and service managers (for both health care and social services). Of these interviews, 12 were with health care staff, 6 were with social care services staff and 5 were with staff who worked between health and social care services. Interviews were carried out between December 2007 and May 2008.

The views of older people in Fife around preferred models of intermediate care were also sought via Fife User Panels, coordinated by Age Concern Scotland, and Fife Elderly Forum groups. A total of 4 Fife Elderly Forum groups and 4 User Panel groups were attended between January 2008 and April 2008.

In addition, MG attended a total of 5 relevant team meeting or events which had intermediate care as a focus.

Analysis of quantitative data

In order to describe the population who might benefit from intermediate care services in Fife, both locally and nationally collected quantitative data was analysed.

The SMR01 dataset is collected nationally by Information Statistics Division (ISD) and describes discharges from non-obstetric non-psychiatric hospitals in the NHS in Scotland. SMR01 data was requested for the years 2004-2007 for Fife residents aged over 65 and this allowed a descriptive statistical analysis to be undertaken to show the number of people over the age of 65 being admitted to hospital as an emergency. This would provide an estimate of the number of people over 65 in Fife who might access intermediate care services.

To identify intermediate care services currently in existence in the Fife area, data from the Point of Access for Community Teams (PACT) and Single Point of Access (SPOA) was requested. These datasets provide information on referral to community teams in the Dunfermline/ West Fife and Glenrothes/North East Fife areas respectively.

In order to describe an example of the usage of a team providing intermediate care services, data was requested from Integrated Response Teams in each of the localities.

Caldicott Guardian Approval

Approval was sought from the NHS Fife Caldicott Guardian in order to gain access to patient identifiable data for each of the Fife quantitative datasets. Patient identifiable data was used only to identify patients who had used any of the services on more than one occasion.

Ethical Approval

Following guidance provided by the National Research Ethics Service (<http://www.nres.npsa.nhs.uk/>) this needs assessment is classified as "Service Evaluation" and so approval from the Local Research Ethics Committee was not required.

Consultation

In order to gather comments and feedback, a draft report was circulated throughout Fife in June 2008 to appropriate groups with an interest in older peoples services. Details of the groups/individuals who received a copy of the draft report are provided in Appendix 1.

Recipients were asked to circulate the report widely with the request that any comments or feedback be returned by August 22nd, 2008. Comments and feedback were collated and are presented in Appendix 2.

Where comments related to factual inaccuracies in the draft version of the report, these have been corrected for this final version. Other comments have also been considered but no other changes were thought appropriate to make to the report. All comments have been included in Appendix 2.

Investigators

Mhairi Gilmour was lead investigator for this needs assessment and carried out the literature review, qualitative interviews and the quantitative analysis of local PACT/SPOA data. MG also wrote the first and subsequent drafts of the report.

Jo-Anne Valentine carried out the quantitative analysis of the national data and the local Integrated Response Team data.

Gordon McLaren advised on the remit, provided detailed comments on draft reports and supported the work throughout.

6 Findings

6.1 Literature review on models of intermediate care

Through searching Ageline, CINAHL, Embase and Medline publication databases, a total of 152 abstracts were reviewed with relevant articles being identified for further consideration.

The internet was also used to identify sources of grey literature i.e. published non-academic reports around intermediate care. Several key reports and publications were identified using this method. The key findings from the literature review were as follows:

Intermediate Care as a Concept in the UK

In England, the National Services Framework for Older People (published 2001)⁵ mandates the introduction of “Intermediate Care Services” to reduce emergency admissions to hospital for people aged 75 and over.

Standard 3 states:

“Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and Councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.”

Intermediate care services were supposed to “assist the transition from hospital to home, and from medical dependence to functional independence”. It was recognised that intermediate care should not provide mainly medical care but assist the patient in being “functionally fit enough to return home”.

The document talked about “integrated services”, “promoting faster recovery”, “preventing unnecessary acute hospital admissions”, “supporting timely discharge” and “maximising independent living”. It also talked about freeing up beds in the acute setting so these can be used more appropriately.

Since the publication of the National Services Framework for Older People in 2001, there have been a plethora of publications discussing the definition of intermediate care, the advantages and disadvantages of intermediate care as a concept, the types of intermediate care models and the challenges with evaluating intermediate care services^{6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17}.

There have been fewer publications discussing intermediate care from the service users’ perception^{18,19}.

A key paper was published by The British Geriatrics Society (BGS) in 2003²⁰. The paper discussed how between 5 and 10% of emergency admissions could be prevented through using intermediate care services accessed from Accident & Emergency Departments and Medical Admission Units. It also discussed how significant reductions in bed days occupied could result from timely access to intermediate care schemes. It stated that the early

involvement of Geriatricians and Specialist Nurses would be critical to enhance decision making.

The BGS paper identified three key points of the patient journey where intermediate care models could be beneficial:

- Managing crises in the community and at home. This would assist in preventing avoidable admissions to hospital and would require early access to assessment and crisis support in the community.
- Managing crises at the front door. This requires early assessment in Medical Admissions Units or Accident & Emergency Departments to identify whether the patient can be returned home with appropriate support or whether the patient needs to be admitted. In order to return a person home with appropriate support, rapid access to community services would be essential.
- Managing post-acute phase. This requires clear pathways to services providing support in the post-acute phase. Clear referral paths, eligibility criteria, appropriate assessment and timely access to appropriate services are all key to managing the post-acute phase of a crisis. BGS includes recuperation beds, reablement beds, home care and falls assessment as all being appropriate services for managing the post-acute phase.

In summary, the term “intermediate care” has been used in England for several years. Intermediate care is a key aspect of providing services for older people in England and work is continuing around developing these services further.

Intermediate Care in Scotland

Several key policy documents published by the Scottish Executive/ Scottish Government in recent years mention intermediate care but do not define the term or discuss in detail what intermediate care actually is.

In 2003, the Scottish Executive published its White Paper: Partnership for Care²¹ and mentioned intermediate care under “Acute Services”. It discussed the impact of service redesign and in particular stated that “new intermediate care and rehabilitation services will be required particularly for older people”. It did not explain what those new intermediate care services would entail.

In 2005, the Social Work Research Centre (University of Stirling) were commissioned to prepare a report for the Scottish Executive as part of the 21st Century Social Work Review²². Effective Social Work with Older People²³ mentioned intermediate care as part of the recovery process of an older person following a crisis. It also highlighted that psycho-social recovery is as important as physical recovery in order for a person to fully recover from a crisis and “enable a return to a reasonable quality of life in their own home.” It did not provide further information on what intermediate care is.

A definition for intermediate care was suggested in Better Outcomes for Older People: Framework for Joint Services (2005)²⁴. This framework for the development and mainstreaming of joint and integrated services for older people in Scotland defined intermediate care as:

“A short period (often defined as no longer than six weeks) of intensive rehabilitation, treatment and/or care at home to:

- Prevent unnecessary hospital admission
- Prevent inappropriate admission to long-term residential care
- Enable patients to return home following hospitalisation”

Several projects throughout Scotland were given as examples of joint working between health and social care with terms such as “rehabilitation”, “enhanced respite care”, “step up/step down”, “crisis response”, “discharge support”, “care at home” and “integrated care” all being used to describe the intermediate care services being provided.

The Range and Capacity Review Group, set up in response to the National Delayed Discharge Action Plan published in 2002, published their second report in 2006. The Future Care of Older People in Scotland paper²⁵ highlighted that intermediate care is a term that means different things to different people. The paper raised concerns around intermediate care being used as another tier in the NHS. Instead, the group preferred to talk about “step up/step down/rehabilitation services” that could be pro-active in supporting people remain living at home or actively support older people on returning home.

This paper also highlighted that such services are often already in place, but operate separately and “not as part of a continuum of care”.

In “Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland”, published in February 2007⁴, intermediate care services are defined as “those that do not require the resources of an acute hospital but are beyond the scope of traditional primary and secondary care services”. It highlights that whilst intermediate care has not featured as a key policy driver in Scotland, many projects are now underway to develop intermediate care services and highlights the work of the Joint Improvement Team in supporting a national Intermediate Care Learning Network in Scotland.

The Intermediate Care Learning Network, established by the Joint Improvement Team, has provided an opportunity for various groups throughout Scotland to share learning around developing intermediate care services. This has been facilitated through a series of learning events where topics have included:

- The role of intermediate care in supporting the implementation of the Adult Rehabilitation Framework
- Scoping the intermediate care initiatives in Scotland
- Intermediate care services for people with dementia
- The role of housing in intermediate care
- Agreeing a common definition of intermediate care
- Evaluating intermediate care

Further details of these events, and accompanying reports, can be found at www.jitscotland.org.uk.

In summary, in contrast to England there has been no clearly identifiable strategic drive at a national level to develop intermediate care services in Scotland. There is, however, evidence that intermediate care is included in local health and social care agendas throughout Scotland.

Definition of Intermediate Care

There have been numerous definitions of intermediate care provided through the years, including the following:

- “Those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team”².
- “A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living”³.
- “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. It’s aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care”²⁶.
- “a range of services, which are provided in the community, which:
 - Help people to recover from illness more quickly.
 - Prevent them being admitted to hospital unnecessarily.
 - Help them to be sent home from hospital as soon as they are able to.
 - Help them to remain living as independently as possible in their own home wherever possible”²⁷.
- “Care falling between the traditional home/care home/hospital pathway. Bridging acute hospital and care in the community. It includes rehabilitation and step-up and step-down.”¹²
- “Skilled nursing care provided to patients who would otherwise be in an acute care hospital setting.”²⁸
- “Hospital care provided in community facilities for less serious conditions so patients do not have to be admitted to an acute hospital, or providing support for patients once they have been discharged from an acute hospital (sometimes referred to as convalescence).”²⁹
- “For the medically stable patients with a focus on confidence building. Patients need ongoing physiotherapy, occupational therapy and speech therapy”.³⁰

In summary, the definitions of intermediate care vary from publication to publication with some being quite broad and others being quite specific and exclusive about the premises and staff that provide intermediate care.

For the purposes of this needs assessment, no one definition will be used. Instead the broad concept of providing a service to help keep patients out of hospital or support patients being discharged from hospital will be used.

Models of intermediate care: JIT Scoping Exercise

A substantial scoping exercise of intermediate care initiatives in Scotland was undertaken in 2007 through the Intermediate Care Learning Network facilitated by the Joint Improvement Team.

In order to avoid duplication, this paper will not go into detail about the individual initiatives described by this scoping exercise. Instead a summary of the models identified is provided in Appendix 3. The original scoping paper can be accessed at <http://www.jitscotland.org.uk/knowledge-bank/publications.html?category=Intermediate+Care>.

Published models of intermediate care

The published evidence shows the majority of intermediate care models fall into two categories: those that support prevention of unnecessary admission to hospital and those that support discharge from hospital. Although these were the two main reasons for intermediate care, other reasons included providing respite for carers and providing transitional care for those people awaiting community care packages to be organised. This section summarises the various models of intermediate care.

Many different models of intermediate care were identified in the published literature. These included rapid response teams, community assessment and rehabilitation teams, residential re-ablement schemes, hospital at home schemes and the use of community hospitals to provide intermediate care services.

The Joint Improvement Team Intermediate Care Learning Network also held an event in April 2008 to share good practice around housing and care home models of intermediate care. Further information can be found on the JIT website at www.jitscotland.org.uk.

Hospital at home schemes

Hospital at home schemes can be used for both prevention of admission and supporting discharge by providing care at home that would otherwise require a hospital stay.

Hospital at home schemes can be used for patients suffering from a specific condition that would normally require hospital care. Examples of this include the Home Parenteral Nutrition service³¹ provided across Scotland for treating patients with chronic intestinal failure and the Home Parenteral Antibiotic Therapy Service in Greater Glasgow³².

A Cochrane Review undertaken in 2005³³ examining hospital at home schemes for adults found that most trials evaluated early discharge schemes while only a few focused on schemes set up either in the community or an Emergency Room to prevent patients being admitted to hospital.

The review found that patients admitted to hospital at home did not generally have significantly different outcomes than those treated in hospital. Furthermore, the review found that while there is some evidence that patient satisfaction may be higher at home, the burden on carers can also be greater and there is little evidence of cost savings to the health service. This supported similar findings from previous work³⁴.

Hospital at home: A Fife Example

An example of the Hospital at Home Model in Fife is the Care at Home team in the Dunfermline and West Fife area.

This service assesses and enables frail elderly people (over the age of 65) to remain in their own home and provides mobile hoists, hospital beds, professional advice, support and enhanced nursing care.

There is no time limit for this service.

Community hospitals providing intermediate care

In 2004, the Scottish Associations of Community Hospitals undertook a “National Survey of Intermediate Care”³⁵ which acted as a “stock-take exercise” to determine what services were provided by primary care practices admitting to Scottish Community Hospitals. This work highlighted that primary care practices provided a variety of services such as blood testing/monitoring, drug management and preventative care. Although such services are important in ensuring a patient does not get admitted to hospital in the first place, this paper does not provide details of how community hospitals can provide models of intermediate care.

Examples of where community hospitals do provide intermediate care included one in Bradford³⁶ which provided services to support prevention of admission and discharge from hospital. Services were provided by a multi-disciplinary team including nursing staff, healthcare assistants, physiotherapists, occupational therapists, a dietician and a Consultant in Care of the Elderly. Out of hours cover was provided by GPs.

Evaluation of this initiative is currently being undertaken via a prospective randomised trial looking to quantify post-acute care to use as an estimate of intermediate care.

Community Hospitals are often seen as an interface between acute and primary care and are well placed geographically for providing care closer to home. They are often seen as an important part of local communities and as such, play an important role.

In 2006, *Developing Community Hospitals: A Strategy for Scotland*³⁷ was published and outlined the ways in which community hospitals could be developed to “act as a local community resource centre and provide a bridge between home and specialist hospital care, through the delivery of both ambulatory and/or inpatient services closer to communities.”

It discussed how community hospitals could “strengthen the primary-secondary care interface by providing intermediate care” but did not recommend any actual model.

The paper also highlighted the benefits to patients of remaining in their local community and recommended that consideration be given to placing community casualty units in local community hospitals.

In summary, Community Hospitals are currently providing intermediate care in different ways including dedicated intermediate care units and use of rehabilitation beds and wards. If recommendations for developing community casualty units were taken on board, these could also be used to carry out assessments to determine whether an older person can benefit from services aimed at preventing unnecessary admissions.

Community hospital based intermediate care services in Fife

There are several community hospitals in Fife, each with a variety of rehabilitation wards, day care wards, GP beds and care of the elderly beds.

Patients receive a variety of intermediate care services through community hospitals in Fife in each of these settings.

It should be noted that there are no community hospitals in the Dunfermline and West Fife area. However, there are three designated intermediate care beds in Lynebank Hospital in Dunfermline.

Nurse led, acute inpatient units providing intermediate care

Several examples of nurse led intermediate care units were identified in the literature^{38, 39, 40}.

The JIT Scoping Exercise provided details of a nurse led unit in The City Hospital in Aberdeen³². This unit is nurse led with GP support and offers assessment, investigation and treatment, rehabilitation, palliative and terminal care – services that can support prevention of admission or discharge from hospital. Evaluation of services is by user satisfaction monitored via a survey of the Single Shared Assessment. An audit of services is also underway.

A Cochrane Review looking at the effectiveness of intermediate care in nurse led units was carried out in 2004⁴¹ and found that patients in nurse led units “benefit (or at least fare the same) as patients receiving “normal” care”. Patients in nurse led units also functioned better and experienced greater well-being. Patients remained in hospital longer but fewer were re-admitted to hospital soon after discharge. The results were inconclusive as to whether nurse led units were more cost effective than “normal” care.

There are no examples of hospital based, nurse led units providing intermediate care services in Fife at the present time.

Intermediate care centres

There were several dedicated “Intermediate Care Centres” identified when looking for examples of models of intermediate care^{42, 43, 44, 45}. One example was also provided in Better Health for Older People, published in 2004⁴⁶ and described a joint venture between the City of Sunderland Social Services,

Sunderland PCT, Sunderland City Hospital and South of Tyne & Wearside Mental Health Trust.

The facility is a 52 bed centre for medically stable patients to receive short term rehabilitation (for people who need a safe and supportive environment with rehabilitation whilst awaiting a care package or '24 hour' care setting) and medium term rehabilitation (for people who would benefit from intensive rehabilitation programmes). The centre also provides dementia care rehabilitation.

The facility won Queen Mothers Award for Intermediate Care for Older People at NHS Health & Social Care Awards, 2004.

There are no dedicated intermediate care services in the Fife area. There are however, numerous wards providing a variety of rehabilitation packages to people with a variety of medical conditions.

Nursing home models of intermediate care

Nursing homes have been used in several instances to provide intermediate care services⁴⁷.

Zaatar (2002)⁴⁸ described an intermediate care scheme piloted in the Liverpool area where a number of beds were purchased in local, privately owned registered nursing homes. Home staff were trained to provide rehabilitation and physiotherapy, occupational therapy and social work support was available when required. Local GPs were paid to provide medical cover.

Evaluation of the scheme showed a slight increase in the number of patients over the age of 65 being admitted to local general hospitals but a decrease in the average length of stay for patients admitted through A&E. Over 75% of service users who completed evaluation questionnaires reported "they would rather be in the nursing home for their rehabilitation than in hospital or at home". Details of the questions asked or the method of gathering responses from service users were not provided in the paper.

The paper identified some of the challenges in providing intermediate care in a nursing home setting including training of staff and public perceptions of nursing homes which are perceived to provide long term care, often at the end of life.

Other papers⁴⁹ identified some of the other challenges of using nursing homes to provide intermediate care services including difficulties in accessing GP services, in communicating with primary and secondary care, accessing rehabilitation services and equipment. The authors noted that if these issues are not resolved, "bed blocking will only be shunted to independent sector".

An example of where the nursing home model of intermediate care has been implemented in Scotland is in Angus where a number of intermediate care beds are commissioned in an independent nursing home. The service was available to support prevention of admission and discharge from hospital. In the year 2007/08, a total of 68 people used the service with the majority

returning home with the same care package. A previous evaluation⁵⁰ of the service identified areas where lessons could be learned including:

- Extending the times when a person could be referred to the scheme beyond office hours increased the bed occupancy
- The geographical location of one of the nursing homes used previously resulted in lower occupancy
- Ensuring that service users are clear about the purpose of the placement i.e. “an opportunity for short term rehabilitation with the aim of maximising independence”

Staff, service users and family all reported positive benefits of the scheme through evaluations including improved joint working and reduction in the need for hospitalisation or longer term care.

At the present time, there are no examples of nursing homes being used to provide intermediate care in Fife. However, one nursing home has been used in the past to provide intermediate care beds. Further details are provided in Section 6.2.2.

Residential care homes as an intermediate care model

Several examples of residential care homes providing intermediate care were identified as part of the scoping exercise undertaken by JIT³². Services provided by this model of intermediate care included support for preventing admission, supporting discharge from hospital, support for people who have the potential for rehabilitation to enable them to remain in community and avoid/delay admission to residential care.

Models were evaluated using a variety of methods including user satisfaction surveys, survey of Single Shared Assessments and audit but little information was provided on the actual details of the methods used or the outcomes.

There were very few relevant publications providing details of residential care home based models of intermediate care in the published literature. Publications often mentioned these types of models existed but provided no further details.

There are currently no residential care homes providing intermediate care services in the Fife area. However, residential care homes have been used in several instances in the past to provide intermediate care. Further details are provided in Section 6.2.2.

Sheltered housing models of intermediate care

Very few academic publications on sheltered housing models of intermediate care were found from searching publication databases such as Medline, CINHAL or Ageline.

However, when searching for the terms “intermediate care” and “sheltered housing” using Google, several papers describing this type of model were found.

Herbert (2002)⁵¹ reported on the use of a sheltered housing provision to facilitate intermediate care. Evaluation showed that the majority of service users returned to a more independent lifestyle and required less home care on discharge.

A paper published by the Health & Social Care Change Agent Team⁵² described the development of a sheltered housing model of intermediate care and some of the key lessons learned. These included the importance of educating staff in mainstream services of the objectives, specific features and potential benefits of sheltered housing based intermediate care services, noting that “the model of extra care housing may be unfamiliar or perhaps indistinguishable from a residential care home”.

The scoping exercise undertaken by JIT identified one model of sheltered housing based intermediate care service – Smithfield Court in Aberdeen. This model provides services to support both prevention of admission and discharge from hospital. It also provides services for people considering a move to care home. Evaluation of the services is via user satisfaction, monitored via a survey of the Single Shared Assessment. An audit of services is also underway. No further details about evaluation were available.

Sheltered housing based intermediate care: A Fife example

At the present time, three sheltered housing units have been commissioned for use in providing intermediate care services in West Fife.

These units enable people to have a period of rehabilitation in a homely environment prior to returning home.

The level of occupancy of these units has been variable and possible reasons include the purpose and function not being fully understood, the perception that the service is not providing anything additional to returning home with integrated response team support and potentially that staff are too “risk averse” and so patients remain in hospital past the stage in their journey where this model may be of benefit.

Work is currently underway to identify ways to improve occupancy of these sheltered housing units including extending the eligibility criteria and considering other potential uses for these units.

Further information on the challenges around the sheltered housing model of intermediate care in Fife is provided in Section 6.2.13.

Team based models of intermediate care services

The published literature identified a plethora of teams providing different forms of intermediate care. Some of the models described teams who provided an intermediate care function in several different settings e.g. a patient’s home, a care home, a nursing home, sheltered housing complex.

It should also be noted that the term “integrated” is used extensively throughout published literature on intermediate care with many articles

discussing whether intermediate care is indeed integrated care with another name.

When looking at published literature on intermediate care teams, it is impossible to distinguish the difference between the services provided by the differently named teams and so comparison of the models is unfeasible. This is reflected in the lack of quality studies comparing the differently named teams providing similar intermediate care services. The main characteristic of the team is that it is multi-disciplinary and can include nursing staff, physiotherapy staff, occupational therapy staff, social workers and home care managers.

The names for these teams include “Intermediate Care Team”, “Community Rehabilitation Team” and “Integrated Response Team”. Indeed, the scoping exercise undertaken by JIT³² identified an “Interdisciplinary Response & Intervention Service” and a “Discharge & Rehabilitation Team” which were part of the same “Integrated Discharge Management” model.

Examples of teams providing intermediate care services in Fife

If the key purpose of intermediate care is to support prevention of admission and early discharge from hospital, there is an extensive list of teams throughout Fife who provide that service. These include:

- Community rehabilitation teams
- Integrated response teams
- Enhanced health care teams
- Fife Falls Response Service

Rapid response teams

Rapid response teams can be based in a hospital or community setting but their key feature is they can respond to provide services quickly. These teams are most often involved in providing services that support preventing unnecessary admission to hospital.

Several examples of rapid response team were identified through the JIT scoping exercise³², several of which were based in the community and supported prevention of admission through rapid assessment and subsequent implementation of appropriate services.

On searching the published literature, rapid response teams were mentioned but little further detail was provided. Wade (2004)²⁸ wrote that the development of rapid response teams had lagged behind the development of other teams providing intermediate care and suggested that this might be a result of the nature of the role rapid response teams play i.e. their key role is to respond to requests quickly. Being able to respond to requests quickly often means a team has to be available outside office hours and also has to be able to access services outside office hours. These are often challenges which are hard to overcome.

Rapid response teams in Fife

At the present time, there is a Rapid Assessment and Discharge Team based in the Accident Emergency Departments at both acute hospital settings in Fife.

These teams undertake assessments of people coming through Accident & Emergency and Acute Medical Assessment Unit in order to determine whether the person requires to be admitted to hospital or can return home with appropriate support.

Until recently, a Home Care Manager was part of these teams, enabling home care services to be accessed quickly.

Evaluation of intermediate care models

The published literature has shown many different models of intermediate care, each slightly different to the next. This makes comparative evaluations very difficult. There is no one model of intermediate care that suits all situations and circumstances.

In 2006, Mulley⁵³ talked of the area of intermediate care in England being “an evidence-free zone, rolled out before we know which components are effective”.

The British Geriatrics Society²⁰ noted the challenges with identifying evidence to compare the services provided by the majority of intermediate care schemes with the services provided in an acute hospital setting but provided the following summary:

- Hospital at home schemes appear to offer a valid alternative to hospital inpatient care for certain categories of patient but there is insufficient evidence at present to evaluate the role of community rehabilitation teams other than those providing specialist stroke services.
- Evaluations suggest day hospital care is at least equivalent in effectiveness to comprehensive geriatric assessment in traditional settings while evidence of effective outcomes from community hospital care remains lacking.
- Nurse led units provide a safe alternative to traditional hospital wards but may prolong length of stay.
- Care home based rehabilitation has not been evaluated and may be limited by low levels of therapy input.

Petch¹⁸ also noted that “the provision as a whole needs to be looked at and that too rigid a focus on individual components and their evaluation may be misleading.”

This paper focussed on the user perceptions of intermediate care services and noted that evaluation reports often referred to service-process outcomes as measures of success.

The author suggested that it is “possible to distinguish between quality of life outcomes and service-process outcomes” and that evaluation projects should also “add outcomes relating to improving physical or mental state”.

The author also noted that asking older users of services about their satisfaction can have issues as older people are more likely to respond positively due to fear a service might be removed or unwillingness to criticize individual service workers.

In particular, the author suggested that, when evaluating intermediate care initiatives, the following questions should be considered:

- Is early discharge the preference of older people?
- What has been the experience of those discharged to home based support?
- What are the views of older people on moving from hospital to an alternative location prior to going home?
- Do older people prefer to receive support in their own home in a crisis situation?
- What is the impact of time limits for the delivery of intermediate care?
- What is the impact on older people and informal carers of providing intensive support in their own home?
- In what ways does intermediate care contribute to or detract from the provision of a seamless service?
- How do older people respond to changes in support workers and providers?

In 2006, the findings from the national evaluation of intermediate care for older people were published⁵⁴ and highlighted some key aspects of intermediate care for older people in England:

- There was a significant level of diversity in the interpretation of the official definition of intermediate care and subsequently in the development of intermediate care models.
- The majority of intermediate care services were concerned with providing support for discharge from hospital.
- Main localities had great difficulty in providing simple descriptive data on intermediate care services.
- Effective partnership working between health and social services organisations at both operational and strategic levels was identified as the most important lever in facilitating the development of intermediate care in local contexts.
- Lack of awareness, resistance, concerns about effectiveness and the inability of intermediate care services to always respond positively to referrals means that intermediate care is not being used to its full potential or is being used inappropriately at times.

- There appears to be a need for greater clarity regarding the role of sheltered housing in the context of under- and inappropriate use. The increased engagement and involvement of medical staff (i.e. GPs and hospital doctors) was also felt to be another priority.
- The intermediate care label was being used to describe services that pre-dated the official guidance and some conventional services (community hospitals, domiciliary care, community rehabilitation) have been relabelled as 'intermediate care'.
- This diversity in provision was felt to become problematic when trying to evaluate intermediate care and gather evidence for its effectiveness. A systematic literature review carried out by the evaluation team identified relatively little evidence on the effectiveness or cost-effectiveness of admission avoidance services. However, case-studies and process modelling undertaken as part of the evaluation identified the following:
 - Residential intermediate care services have a higher cost than non-residential services, and admission avoidance schemes have a lower cost than supported discharge services.
 - The largest gains in quality of life were seen for residential services (compared to non-residential) and for admission avoidance schemes (compared to supported discharge).
- Based on the above findings, the authors reported that the results provided strong support for a focus of resources more on admission avoidance intermediate care services as opposed to supported discharge services.

6.1.1 Key findings from literature review

- Intermediate care has been a key focus of health and social care policy in England for several years and many different models of intermediate care have developed in response to this.
- Intermediate care as a concept is not a key driver in health and social care policy in Scotland, although key publications mention intermediate care initiatives as being an important aspect of adult rehabilitation services.
- There are many different definitions of intermediate care in the published literature. The recurring theme is the role intermediate care services play in providing support to prevent unnecessary admissions to and discharge from a hospital setting.
- The key points in a patient's journey where intermediate care might be of most benefit are:
 - Managing crises in the community and at home
 - Managing crises "at the front door" i.e. when patients first present to an acute hospital setting
 - Managing the post-acute phase
- There are many different models of intermediate care. These models can differ according to the location of the care being provided (e.g. patient's home,

hospital ward, residential care home), the team providing the care (e.g. hospital at home team, rapid response team, intermediate care team) or whether a specific condition is being cared for (e.g. falls response, mental health liaison)

- Evaluation of intermediate care initiatives varies widely and there is an overall lack of evidence around cost effectiveness of the various models. A national evaluation of intermediate care services for older people in England highlighted some key learning points around the challenges of intermediate care.

6.2 Findings from qualitative interviews

Interviewees were asked to consider the following topics around intermediate care service provision in Fife:

- Definition of intermediate care
- What teams or services provide intermediate care in Fife?
- What services are in place to prevent unnecessary admission to hospital?
- What are the decision making processes around trying to prevent an unnecessary admission?
- What services are in place to support discharge from hospital?
- What are the decision making processes around discharging an older person from hospital?
- What eligibility criteria are in place for each of these services?
- How does the service in question work with people affected by dementia?
- What works well with regards to these services?
- How could these services be improved?
- What could facilitate improved intermediate care in Fife?

The following key themes emerged:

6.2.1 Definitions of intermediate care

When asked about the definition of intermediate care, stakeholders responded differently, but with a core theme evident:

Intermediate care is the care provided following a crisis to help a patient maintain (prevent hospital admission) or regain (support discharge) as much of their previous independence as possible.

This care can include both health and social care.

Several key points were raised by stakeholders:

- Intermediate care should not be another term for transitional care – there should be a clear purpose to providing intermediate care.
- Intermediate care can be provided at different levels of intensity (e.g. in hospital rehabilitation beds with round the clock health care, in hospital intermediate care beds with round the clock health care, in sheltered housing complexes, at home with an appropriate care package, in day hospitals).
- Intermediate care can also be provided in the longer term to people who require nursing input but are not in the acute phase of an illness (e.g. enhanced health care team).
- Transferring patients to an intermediate care setting/service should not be used as a means of achieving government targets around waiting times or delayed discharges.

6.2.2 Models of intermediate care in Fife

Intermediate care services in Fife can be categorised according to whether the service is provided within an institutional setting (e.g. hospital ward) or in the community (e.g. in the patient's own home with input from a multidisciplinary team).

Institution-based intermediate care is provided in several settings throughout Fife. These include:

- Intermediate care beds (e.g. Ward 1, Lynebank Hospital): Provide period of in-patient rehabilitation/ enhanced care outwith acute hospital setting for 14-28 days.
- Rehabilitation wards throughout Fife hospitals: Intermediate care can be provided as an inpatient (e.g. Lynebank, rehabilitation wards) or as an outpatient attending a day hospital. Community hospitals were felt to play a key role in providing intermediate care services.
- Intermediate care units are also available in a sheltered housing complex in West Fife which can enable people to have period of rehabilitation in a homely environment prior to returning home.

Home based intermediate care is provided by several teams throughout Fife. These include:

- **Integrated response teams:** Provide daily support/ intensive rehabilitation following hospital discharge or to prevent hospital admission for short periods of time.
- **Community rehabilitation teams:** Work with people at home to regain/ increase level of functional independence. Provided 2-3 times a week for approximately 6-8 weeks.
- **Rapid assessment and discharge teams:** Based in A&E departments, provides supported discharge/prevention of admission and follow up at home for equipment provision and referral onto other agencies
- **Care at home teams/Enhanced healthcare teams:** Assesses/ enable frail elderly people over 65 to remain in their own home. Provides mobile hoists, hospital beds, professional advice, support and enhanced nursing care. No time limit for service.
- **Community physiotherapy/occupational therapy teams:** Provides physiotherapeutic assessment and intervention for people in the community.

Several interviewees mentioned that intermediate care beds had previously been accessible through several care homes across Fife. The reasons given for these beds no longer being available included:

1. Challenges around having the optimum numbers of beds in the optimum location. If there were too few beds, throughput of patients could be slow resulting in frustration when trying to refer into these beds.
2. Perceived inflexible criteria for referring to intermediate care beds.
3. Staff employed by the care home were providing a service to intermediate care patients referred from a health care setting. This meant that line management responsibility was not provided by a health care team leader but by the care home manager.
4. Issues around mixing populations of long stay residents with short stay intermediate care patients with different needs.

Care provided to intermediate care patients has the purpose of rehabilitating and re-enabling the person to allow them to return to as much of their previous level of independence as possible in order to return home.

In the case of long stay residents, an assessment has been carried out previously around the person's ability to return home and a decision made that it was in the person's best interests to be cared for in a care home.

By mixing the two populations, two different services were, in essence, being provided, often by the same staff. This was felt to be challenging from the point of the staff being asked to provide different services in the same setting, and from the residents/clients who often

queried why they were not receiving a similar service to another person.

Despite the challenges listed above, interviewees suggested on several occasions that using care homes to provide intermediate care was an area that could be developed further.

6.2.3 Patient journey

Interviewees reported that people mainly receive intermediate care at two key points of their patient journey:

Preventing admission:

When a person suffers a dramatic change in their health or social circumstances, intermediate care can be provided to help that person remain at home. Referrals can be made to community based teams via GPs, District Nurses, Falls Response Service or the Rapid Assessment and Discharge Teams based in A&E departments in QMH and VHK. In the Dunfermline & West Fife and Glenrothes and North East Fife areas, dedicated point of access systems have been established through which community based teams can be accessed.

An important factor in determining whether a person should be admitted to an acute hospital was ensuring that an appropriate assessment was carried out prior to any decision being made. Opinions differed on whether this assessment could only be undertaken by medical staff specialising in geriatric medicine.

In some cases, there was a perception that community hospitals did not have access to full diagnostic facilities/services in order to enable a full multi-disciplinary assessment to be undertaken before deciding whether to admit an older person. Opinions differed on whether access to facilities such as radiology, laboratory testing or full medical cover was essential in order to undertake a full assessment.

Opinions differed on what constituted a “preventable admission”. In some cases, interviewees felt it was appropriate to admit an older person to hospital if their social circumstances had deteriorated – others disagreed and felt people in these circumstances could remain at home with appropriate community based support provided.

It was also highlighted that to provide effective services that prevented unnecessary admissions, teams had to be able to respond quickly and this was generally felt to be an area where improvements could be made. Accessing services out of hours was very challenging and would often result in a person being admitted to hospital.

An example of how such a service could be developed was provided:

- Establish a bank of staff who would be able to respond immediately to set up the services/support required to enable the person to remain at home.

This would help carers in times of crisis which are often short term but the family feels unable to cope at that time. This team could include someone who could act as an assessor – this could be health or social work based staff but needs to be someone who can then access the appropriate services.

Supporting discharge:

When the acute phase of a person's health crisis has passed, intermediate care can be provided to support that person returning home. Referrals can be made to teams providing intermediate care in several ways including via ward staff, hospital based occupational therapists or physiotherapists or hospital doctors.

When an older patient is due to be discharged from an acute setting, a multi disciplinary team meeting will take place to discuss the options for the person in question. This meeting should be attended by the various health and social care professionals involved in that person's care.

However, a key theme to emerge from the qualitative interviews was that there can be a waiting list for social work assessments to be carried out and, as a result, there is a perception that social work input to these multidisciplinary team meetings can vary. Although in theory, a complete social work assessment should be carried out prior to discharge, it was reported that this does not always happen. It was also mentioned that, in some instances, there can be a lack of communication to inform community based social work staff that a patient is either due to be discharged or has actually been discharged.

Once a decision has been made regarding where the patient will be transferred/ discharged to, the appropriate team will be contacted and the transfer/discharge arranged. If a person requires intermediate care, ward staff will contact the appropriate team and request an assessment to be carried out.

It was suggested on several occasions that, on a whole, the entire patient journey is not considered and that different groups provide different support at different points without fully appreciating the different aspects of the other stages of the journey. From a patient's point of view, it is all one journey - it should not start and stop between different teams.

6.2.4 Decision making processes

At the outset of this needs assessment, one of the key aims was to determine whether older people being discharged from a hospital to a care home setting (either residential or nursing home) had sufficient time and opportunity to determine whether that was the right decision for them and whether there was further scope for rehabilitation. Concerns had been raised that, in some cases, decisions were being made too quickly.

To determine whether this was the case, health and social care interviewees were asked about the processes involved in discharging a person to a care home setting.

The general consensus was that, in the vast majority of cases, the decision to discharge an older person to a home care setting was only made after a comprehensive, multi-disciplinary assessment of the person's potential to rehabilitate. If a decision was made to discharge a person to a care home setting, there could then be a period of waiting for a place to become available.

However, several interviewees felt there had been instances where a decision had been made about a person's potential for rehabilitation which resulted in them being transferred to a ward awaiting a care home placement where they had subsequently recovered enough to be able to return home.

Points made around this issue included:

- In theory, there should always be social work input to this decision making process. In reality, there can be a waiting list for full social work assessments to be carried out and, as a result, social work assessments are sometimes not carried out within 6 weeks. This has implications in that acute settings are under pressure to discharge people before 6 weeks to ensure they meet government targets.
- Once a decision has been relayed to families by senior health staff, they can sometimes be reluctant to accept the opinion of social work staff that a comprehensive care package might facilitate that person returning home.
- Discharging older people from general acute wards should not take place without geriatrician input to ensure a comprehensive assessment of that person's ability to rehabilitate is undertaken.

6.2.5 Eligibility criteria for intermediate care services

Interviewees were asked whether there were established eligibility criteria for each service and, on the whole, this was the case.

The majority of eligibility criteria provided related to whether a person would be able to benefit from input from the team in question. In cases where a person would not benefit from input, they would be referred on to a more appropriate team.

When asked about eligibility criteria for people affected by dementia, the overwhelming response was that there were no separate criteria and if people affected by dementia would benefit from that team's input, they would be accepted to that service. Indeed, it was generally felt that a large number of older people accessing intermediate care services suffered from some level of dementia.

It was highlighted that the training needs of staff should be considered to ensure team members were appropriately trained in working with people affected with dementia and at least one team has a dedicated training programme in place for this.

It was acknowledged, however, that in severe cases of dementia, where the person would be unable to retain information to aid rehabilitation, that person would be referred to a more appropriate team who could provide more intensive input. At the present time, there are more specialist teams/services (EAST Team, CAST Team, Mental Health Liaison Team, Psychiatric Liaison

Nurse) which can be contacted in such cases but these are not available Fife-wide.

It was suggested that there may be a role for a specialised intermediate care team to assist discharge from psychiatric wards and provide links with community psychiatric services.

6.2.6 Joint working

Teams providing intermediate care in Fife differed in their composition depending on their primary function.

In general, teams were composed of a combination of health care staff and social care staff. Having this joint working philosophy emphasised that the team were providing person centred care where the patients needs were the main concern - regardless of the balance between levels of health or social care that person was receiving. Each was seen as being equally important to successfully achieving the desired outcome for that person. Regular team meetings were held to discuss caseloads and so a high level of communication was achieved.

Key roles included nursing staff, physiotherapists, occupational therapists, social workers, home care managers, rehabilitation care assistants and clerical/admin staff. Not all teams had representation from all of these staff groups. The majority of teams had a team leader who had responsibility for coordinating the caseload for the team. This person had overall knowledge of each of the cases and the stage they were at in their patient journey.

In some instances, this person was also responsible for coordinating discharge from hospital i.e. identifying patients requiring discharge packages to be put in place. Having a joint role like this had positive and negative aspects as this person would have to split their time between both roles but would also be able to cross over duties between both roles (e.g. undertaking assessment for intermediate care service whilst putting discharge packages in place).

There were also several instances where there was cross training within teams. An example of this was where several team members were trained to carry out assessments, regardless of whether they were health or social care, and this improved the sense of team working. This was also felt to increase team efficiency in dealing with caseloads as no one person would be solely responsible for carrying out this task and so, in times of annual leave or sick leave, there was not an added pressure due to a key person being absent.

A number of teams reported challenges in sustaining full team composition and in particular, in maintaining social worker input to the team. There was a perception that, in some cases social workers who, in theory, were part of a team providing intermediate care services could be pulled away to provide services elsewhere. This was felt to place additional stress on teams.

Teams also commented on times when additional funding was provided to deal with particular issues, the two examples given were winter monies and funds to deal with delayed discharges. Although these additional funds help increase the number of cases a team could take on, it was also commented

that the temporary nature of such funding meant teams were working in an atmosphere of uncertainty about future funding provision. It was also noted that increasing the number of one staff group (rehabilitation care assistants) could result in more people using the service which could result in more people needing input from team members such as physiotherapists which subsequently increased their workload.

In addition to individual team composition, several comments were made around the number of teams in the Fife area with slightly overlapping roles and boundaries. It was commented that some of these teams had been developed due to ring fenced, and hence unsustainable, funding being provided and not as a result of comprehensive needs assessments being undertaken. This resulted in concerns about long term sustainability of these services.

6.2.7 Risk aversion

The topic of “risk aversion” was raised in the majority of interviews.

In some cases, it was felt that staff could underestimate a person’s ability to cope at home and would err on the side of caution when deciding when a patient was fit to be discharged.

An alternative scenario of risk aversion was when a person might have been waiting for suitable housing to be provided and remained in hospital until such housing became available. A query was raised whether people in these circumstances could have been discharged home, with an appropriate care package, until suitable housing became available.

A further scenario was when older people were admitted to hospital following a decline in social circumstances. Again, it was asked whether providing an appropriate temporary care package would alleviate the need to admit that person to hospital.

It was reported on several occasions that extending a patient’s stay in hospital often results in the person losing some of their independence and becoming reliant on hospital staff. This in turn can decrease their confidence levels and so discharging home can become more of a challenge.

6.2.8 Accessing services

This work has identified numerous teams which are involved in providing intermediate care services. In the Dunfermline & West Fife and Glenrothes & North East Fife areas, these teams can be accessed via one single point of access (PACT in Dunfermline & West Fife and SPOA in Glenrothes & North East Fife).

Some interviewees reported that having one point of access was beneficial to ensure referrals to teams providing intermediate care were coordinated effectively. It was suggested on several occasions that these models be developed further to provide overall coordination across each locality in Fife. It was also suggested that a similar model could be developed in the Central Fife area.

However, it was also noted that this model had its challenges with inflexibility being the main concern. Some staff groups have previously been able to refer direct to services across Fife and find they are no longer able to do so. In addition, the single point of access services in Fife are not available 24 hours and so there are issues around what happens when a patient needs referred outside normal working hours. In these instances, it was felt that patients were more likely to be admitted to hospital.

On a few occasions, it was suggested that purchasing beds on ad hoc basis might be a more appropriate method of accessing some intermediate care services. Having a “pot of money” which could be used when intermediate care beds needed to be accessed would mean that beds were being used when required but no further resources would be required to keep them “open” when not being used. This comment was made in reference to purchasing beds in residential homes or sheltered housing accommodation.

It was mentioned on several occasions that there is a lot of capacity in care homes in the Fife area and so beds could be “bought” in as and when they were required. This would also help provide care close to the patient’s home. However, services would need to be configured to ensure that people receiving intermediate care in a care home setting were treated differently to residents as the purpose of them being there was to facilitate rehabilitation and promoting independence.

6.2.9 Home Care Services

The Fife Council website (www.fifedirect.org.uk) describes the services provided by Home Care as follows:

Home Care and Associated Services

The Home Care Service provides a range of flexible care and support to people and carers in their own home.

Following and assessment of need and risk, services are tailored to suit each individual.

Support can include:

- *Assistance with basic domestic tasks within the home*
- *Assistance with personal care tasks*
- *Community Alarm: the installation of a telephone/alarm system to enable help to be summoned in an emergency 24 hours per day*
- *Shopping Delivery and Pension Collection – a weekly service for people who are unable to shop for themselves*
- *Meals on Wheels*
- *Telecare technology to support people at risk live safely at home*

Home care services proved to be a key topic for the majority of interviewees.

There was a perception from some interviewees that delays in accessing home care services could impact on the overall service a person might receive when being discharged from hospital.

If a person has been in hospital for more than six weeks, they will be re-assessed to ensure the care package they receive is still appropriate. Some interviewees reported there could be delays in re-assessments taking place and subsequent updated care packages being put in place.

This could impact on the services provided to a client and, in particular, the role of the rehabilitation care assistants provided via integrated response teams could become blurred in some instances.

Rehabilitation care assistants work with clients following discharge from hospital to build up their confidence in carrying out daily tasks of living. Although the tasks might be similar in some instances to those provided by home carers, the purpose of undertaking that task is entirely different: a rehabilitation care assistant's main role is to assist the client in re-building their skills whilst a home carer would undertake that task without the purpose of rehabilitating the client.

It was reported in some instances that if a home care package was not organised by the time the integrated response team withdrew, support from rehabilitation care assistants would continue to be provided.

With regards to accessing home care services in order to avoid admission to hospital, a recent pilot project where a home care manager was based in A&E Departments reported that this role was invaluable in preventing unnecessary admission to hospital as home care services could be arranged which would allow the person to return home.

6.2.10 Telecare provision

Telecare is being used in several ways to support older people remaining in their own home throughout Fife.

- Currently 6000 users in Fife use Community Alarm (Stage 1 Telecare services)
- Approximately 100 people in Fife have enhanced Telecare packages (Stage 2 – includes movement monitors, pressure pads to monitor movement through house). All are linked up to an alarm system which will send support to the person if required. Support usually arrives within 20 minutes of alarm being raised. The plan is to increase Stage 2 packages to over 200 within the next 18 months.
- A telecare assessment of Dollar Court intermediate care units was being undertaken to identify if telecare equipment could be utilised.
- It is planned to buy mobile equipment that allows such monitoring to be carried out in person's own home – as opposed to moving a person to a new place which may be unfamiliar.

6.2.11 Impact of geographical characteristics of Fife region

Geography was mentioned in several instances as having guided the set up of services across Fife. It was strongly felt by some interviewees that the different localities could not and should not be directly compared to each other due to their different geographies, population composition and acute hospital provision.

Several examples were provided to illustrate these points:

- North East Fife is felt to be an area where older people might come to retire and so the older population is more affluent in this area and unlikely to need health or social care input until later in life (>80 years of age). This resulted in a population who, although they needed input later in life, had more complex needs. There were also fewer family support networks in place as a result of people moving into the area to retire.
- West Fife does not have community hospitals where older people can be admitted. This could possibly have an impact on the number of older people being admitted to acute settings.
- The rural aspects of some areas of Fife mean that staff can spend a great amount of time travelling between patients which can impact on the number of patients who can be seen at one time.

6.2.12 Changing demographics

It has been well documented that the population demographics are changing with more of the population living longer. For further details of the potential impact of projected population changes on services for older people within Fife, see Sections 6.3.1 and 6.3.2.

It was mentioned on several occasions that this change in demographics has not been matched by a change in resources to help support older people in their later years. There are initiatives in place around anticipatory care that aim to identify and support people with long term conditions and the importance of these initiatives was recognised. However, there was a perception from some interviewees that there has not been the same investment in services that provide current support to the older population who would benefit from it now.

It was also noted that the services people require differ from those required in the past. In particular, an example was given relating to the change in type of home care service being provided – in 1999, 55% of home care services provided involved personal care, with 45% involving domestic care. Presently, 80% of home care services provided are for personal care, with 20% being domestic care which has implications for staff training.

6.2.12 What do older people in Fife think about intermediate care service provision?

A total of eight older peoples' groups across Fife participated in discussion around intermediate care service provision in Fife. These groups were a

combination of Fife User Panels and Fife Elderly Forum groups and were asked to consider several key topics:

- **Experiences of discharge from hospital/admission to hospital and involvement of services providing intermediate care**

Group members reported that where they had experienced being discharged from hospital, this had, in general, been a positive experience. They felt involved in discussions surrounding their discharge and some people had experience of receiving input from integrated response teams which they felt had been critical to allowing them to return home following their health crisis.

One group member had previous experience of the Almoner system where discussions were held with a designated individual from the person's church to arrange suitable support when the person returned home and felt this had been a valuable service.

Several people mentioned the "Homeward Bound" service which used to operate from QMH and felt this had been a valuable service in providing support for an older person being discharged home.

Some people had been transferred to a rehabilitation ward following their time in an acute setting and felt this was an appropriate stage in their journey of recovery. These people had also experienced various assessments undertaken by physiotherapists, occupational therapists and home care managers which would enable them to return home and relayed positive experiences.

The work done by Age Concern Scotland around establishing key practicalities for when an older person is discharged from hospital was mentioned on several occasions. This highlighted the importance of support for older people being discharged from hospital (e.g. services in place, a visit from a GP, ensuring heating has been switched on).

- **Preferred model of intermediate care**

There was a clear message around preferred models of intermediate care – it should be appropriate to the individual's needs.

The group members felt that institutional models of intermediate care were appropriate where a person still required some degree of "looking after". Where this type of intermediate care was required, it should be provided as close to the person's home as possible to ensure family and friends could visit. Several members commented on "wards being closed all the time" and suggested these might be used as an appropriate setting.

Several group members used the term "convalescence" when referring to the services that should be provided following discharge but felt there needed to be a balance between recovering from an acute phase of illness and encouraging people to regain their independence. Concerns around some patients "treating hospital like a hotel" were raised on several occasions. There was a general

consensus that remaining in hospital too long could reduce confidence levels and did not help the person in the long run.

6.2.13 Improving intermediate care services in Fife

Each health or social care based interviewee was asked what would improve the provision of intermediate care services within Fife. The responses were very varied and are summarised below.

- **Overall coordination of all intermediate care services through one agency**

As mentioned above, individual teams worked well together and a high level of coordination was evident. However, some interviewees commented that communication between teams based in different localities could sometimes be challenging and ways of improving this were suggested.

- Referrals to the various teams providing intermediate care can be made via several routes. Interviewees who had referred previously felt it would be beneficial if there was a coordinated approach to managing the capacity of the various services.
- A possible model would be similar to that used by the Integrated Admission and Discharge Team for NHS Fife Operational Division where an identified “coordinator” could be contacted to determine which team/ward had capacity to take a patient. Such coordination could take place at a locality level in the first instance.

- **Sheltered housing model of intermediate care (Dollar Court)**

There are three dedicated sheltered housing units in the Dollar Court sheltered housing complex in Dunfermline which provide a setting for intermediate care where people have period of rehabilitation in homely environment prior to returning home. Several interviewees raised concerns about whether these units were being under-utilised.

The sheltered housing model has been successfully implemented in other areas (e.g. Smithfields Court, Aberdeen) and so interviewees were asked about possible reasons the units in Dollar Court are not being utilised. Responses are summarised below:

- The purpose and function of the intermediate care units at Dollar Court may not be fully understood as being mainstream services.
- Dollar Court was not thought to provide anything that can not be provided by sending the patient home with IRT support.
- There is a potential that staff are being too “risk averse” and would prefer to either transfer patients to the intermediate care beds at Lynebank hospital, where round the clock medical cover is available or wait until a patient can be discharged home with IRT support. More information is required around

why staff in acute settings are not considering Dollar Court as an appropriate intermediate care facility.

- Previous experience of inappropriate referrals has resulted in an assessment protocol being established and implemented. In some cases, this can be viewed as being inflexible for staff that could previously refer directly.
- Staff often require immediate answers as to whether someone can be transferred to Dollar Court – however, it takes time to carry out assessment and set up staff for cover. Sometimes staff can transfer patient to other facilities quicker.
- Anecdotal evidence from one client who had used the Dollar Court facilities had been that they felt quite isolated as they were away from friends and family but out of a ward situation where other patients and ward staff provided company.
- Lack of night cover and telecare facilities were also quoted as potential other reasons for the under-utilisation of Dollar Court.

Additional funding has been provided to provide night cover but no requests had been received for this service at the time of writing this report.

As of 7.3.08, an assessment was being undertaken to establish what telecare facilities were required for Dollar Court.

Work is currently underway to identify ways to improve occupancy of these sheltered housing units including extending the eligibility criteria and considering other potential uses for these units.

- **Establishing dedicated “Intermediate Care Facilities” or “Intermediate Care Team”**

Several suggestions were made around developing dedicated facilities where people could receive intermediate care – either to prevent admission to or support discharge.

Feedback from members of Fife User Panels and Fife Elderly Forum, was that developing such facilities in community settings would help provide care closer to home.

It was also suggested that having a dedicated “Intermediate Care Team” might provided a more coordinated approach to providing services. The team could be based on a combination of the various roles and services provided by the existing teams but having one dedicated team would have the benefits of bringing intermediate care into the mainstream, improving joint working within and between agencies and providing a joined up way of working.

- **Improved joint working**

Although individual groups reported that health and social care colleagues were working well together to provide intermediate care (see above), there was still a feeling that there was not a full appreciation of the pressures and circumstances under which different agencies or professional groups worked and which could impact on providing the most effective service.

Examples were provided which indicated that changing government targets, local funding issues and historical differences between professional groups all played a part, both within agencies and between agencies. The two main recurring examples involved delayed discharge targets and issues around accessing home care.

It was felt by some interviewees that having co-terminous boundaries between health and social care services in Fife would help establish more effective networks and so help resolve some of these issues.

In the most part, there was a genuine desire to improve joint working and suggested ways forward included the following:

- Having appropriately aligned budgets for those teams with both health and social care staff
- Providing joint training opportunities whether staff worked in the operational division, community health partnerships or local authority.
- Jointly developing and using IT systems to ensure all appropriate professionals can access the relevant data re service users. This would help with jointly developed care plans.
- Jointly developing eligibility criteria for each of the services and making them available to professionals and service users so people can see what services are available and what they can expect.

6.2.14 Current developments in intermediate care in Fife

Since this needs assessment began in January, 2008, several intermediate care service developments in Fife were reported as being progressed, including the following:

- Proposals for developing joint working between different teams. This would provide a more coordinated approach to providing intermediate care services.
- Proposals for expanding existing teams to allow an increased number of patients to receive intermediate care services. This in turn, will allow more people to be discharged from hospital in a timely fashion and so impact on patient flow.
- Proposals to further develop key roles including A&E based Home Care Managers. Such roles would provide additional support for preventing unnecessary admissions.
- Proposals for coordinating referrals to the numerous teams involved in providing intermediate care services through a single point of access.

- Providing training for home care staff to allow them to play an increased role in providing intermediate care services.
- Redesign of services to build on lessons learned from past experience.

6.2.15 Key findings from qualitative interviews

The key findings from the qualitative interviews were as follows:

- Intermediate care was broadly defined as covering the ranges of services in place to prevent unnecessary admission to hospital or support discharge from hospital. Further discussion around what services or teams should be classed as providing intermediate care would be beneficial.
- There are many different teams throughout Fife providing support to people being discharged from hospital and, to a lesser extent, support to prevent unnecessary admission to hospital. These include Integrated Response Teams, Community Rehabilitation Teams and Rapid Assessment & Discharge Teams. The Fife Falls Response Service also plays a key role in preventing unnecessary admission to hospital. There may be overlaps in the services provided by these teams.
- The decision to discharge an older person is undertaken following a multi-disciplinary assessment to determine that person's potential for rehabilitation. Issues were raised around this process including social work input and acceptance by families of the decision that had been made. The timescale of this work did not allow the experiences of an older person who had been through this process to be explored further.
- People affected by dementia make up a considerable proportion of the clients seen by teams and services providing support to prevent unnecessary admission and support discharge from hospital.
- Joint working between health and social care services was seen as being key to providing effective intermediate care. Team composition differed depending on the main function of that team. Joint working between acute and community based health care staff was also noted as being important to providing effective intermediate care.
- There were some concerns raised that staff are too "risk averse" and tend to err on the side of caution when deciding when a patient was fit to move to the next stage of their journey.
- It was suggested that a more coordinated approach to the various teams providing intermediate care might be beneficial. Concerns around this included having to refer via one point of access and providing such a service on a 24hr basis.
- There were differences of opinion around using residential or nursing home beds to provide intermediate care.

- Accessing home care services was felt to be an issue by some interviewees and this could impact on the role of rehabilitation care assistants provided via integrated care teams.
- Telecare can provide important support to help older people remain in their home.
- Older people in Fife, via the Fife User Panels and Fife Elderly Forum, felt that the model of intermediate care should reflect the needs of the individual. It was highlighted that some people may need nursing care whilst others function better at home. It was also highlighted that remaining in hospital too long had a negative impact on a person's confidence level which did not help in the long term.
- Several ways of improving intermediate care services in Fife were provided including overall coordination of all intermediate care services through one agency, establishing dedicated intermediate care teams or facilities and continuing to promote joint working between appropriate stakeholders.
- Several intermediate care initiatives have been progressed including joint working between different teams, expanding existing teams, proposals to develop key roles such as A&E based Home Care Managers.

6.3 Quantitative analysis

6.3.1 Demography

Figures from the General Register Office for Scotland⁵⁵ show that, in Scotland as a whole, the population of people aged 65 and over is projected to increase by approximately 33% between 2006 and 2021 (see Table 1).

The greatest projected increase is 67.6% for people aged 85 and over. In particular, the number of males aged 85 and over is projected to increase by approximately 118%.

Table 1*: Projected population change for older people aged 65, 75 and 85 years and older in Scotland between 2006 and 2021							
	Number				% change from 2006		
	2006	2011	2016	2021	2011	2016	2021
Males aged 65+	348925	386026	447647	497755	10.6	28.3	42.7
Females aged 65+	489043	512640	566210	614234	4.8	15.8	25.6
Both genders aged 65+	837968	898666	1013857	1111989	7.2	21.0	32.7
Males aged 75+	140573	161341	187793	220727	14.8	33.6	57.0
Females aged 75+	241651	255628	276246	305494	5.8	14.3	26.4
Both genders aged 75+	382224	416969	464039	526221	9.1	21.4	37.7
Males aged 85+	27191	35108	45181	59223	29.1	66.2	117.8
Females aged 85+	68012	75730	85471	100339	11.3	25.7	47.5
Both genders aged 85+	95203	110838	130652	159562	16.4	37.2	67.6

Source: General Registrars Office 2006 Projections (Scotland)

Table 2 shows projected population figures for Fife. The number of older people in Fife aged 65 and over is projected to increase from approximately 59840 in 2006 to approximately 83850 in 2021 – an increase of 40.1%.

As per the Scottish scenario, the greatest projected increase is approximately 68.4% for people aged 85 and over and in particular the number of males aged 85 and over is projected to increase by 115% between 2006 and 2021.

The figures also show that the proportion of people over the age of 65 as a percentage of the total Fife population will rise from 16.7% to 21.6% between 2006 and 2021.

There is also a marked gender difference in the projected population increase for older people; the percentage increase for males being greater than that for females. The largest difference is in the over 85 years age group with the

□ **NB** The figures provided in Tables 1 and 2 were published by the General Register Office for Scotland in 2006. As these figures are based on estimates of future populations, they can only provide a guide and approximation of the future populations of Scotland and Fife.

number of males projected to rise by over 115% compared to 50% for females.

Table 2*: Projected population change for older people aged 65, 75 and 85 years and older in Fife between 2006 and 2021							
Age group	Number				% change from 2006		
	2006	2011	2016	2021	2011	2016	2021
Males aged 65+	25040	28642	33645	37398	14.4	34.4	49.4
Females aged 65+	34800	37634	42576	46452	8.1	22.3	33.5
Both genders aged 65+	59840	66276	76221	83850	10.8	27.4	40.1
Males aged 75+	10117	11749	13842	16842	16.1	36.8	66.5
Females aged 75+	17617	18686	20334	23267	6.1	15.4	32.1
Both genders aged 75+	27734	30435	34176	40109	9.7	23.2	44.6
Males aged 85+	2027	2570	3296	4365	26.8	62.6	115.3
Females aged 85+	5187	6001	6703	7780	15.7	29.2	50.0
Both genders aged 85+	7214	8571	9999	12145	18.8	38.6	68.4

Source: General Registrars Office 2006 Projections (Scotland)

When compared to Scottish figures, the older population in Fife is predicted to increase at a rate higher than the Scottish average. The exception to this is for males aged 85 and over where the Scottish average is slightly higher than the Fife increase.

This projected increase in the population of older people in Fife will have significant implications for service provision.

6.3.2 Emergency admissions of older people to hospital in Fife

Table 3 shows the number and rate per 1000 population of people aged 65 and over who were admitted to hospitals within Fife as an emergency between the years 2004 and 2007.

Table 3: Emergency admissions of people aged 65 and over to hospitals in Fife between 2004 - 2007						
Age group	Average number of admissions per year			Average rate per 1000 population		
	Male	Female	All	Male	Female	All
65-74	1162	1139	2302	79	66	72
75-84	1125	1520	2645	140	122	129
85+	454	992	1446	245	202	213

All aged 65+	2741	3652	6393	111	106	108
Source: ISD Scotland SMR01 (General / Acute Inpatient and Day Case) data, 2004-2007						

Given that the population of people aged 65 and over in Fife is projected to increase by approximately 40.1% by the year 2021 (see Table 2), this is equivalent to an additional 24010 people in this age group*.

Using the average rates of admission provided in Table 3, the number of emergency admissions for people aged 65 and over can be projected to increase to 9056 in 2021.

The figures also show that people aged 85 and over have a much higher rate of emergency admission to hospital compared to other age groups. In particular, males aged 85 and over have the highest rate of emergency admission to hospital with 245 being admitted for every 1000 population.

Given that the number of males aged 85 and over in Fife is projected to increase by approximately 115% by the year 2021 (see Table 2) - this is equivalent to an additional 2338 individuals in that age group, giving a total of 4365 males aged 85 and over living in Fife in 2021.

Using the average rates of admission provided in Table 3, the number of males aged 85 and over who are admitted to hospital as an emergency in 2021 is estimated to be 1069 – an increase of 572.

These figures give an indication of the potential increase in service demand for the older population in Fife in coming years.

6.3.3 Analysis of local data

Two local data sources were available at the time this work was carried out which describe some of the teams providing intermediate care services in the Dunfermline & West Fife and Glenrothes & North East Fife areas. However, these datasets can not be analysed as one due to the different timescales covered.

Point of Access to Community Teams (PACT)

The “PACT” dataset is collected by the Point of Access to Community Teams service in the Dunfermline and West Fife area. This service acts as a gateway for all referrals to community teams in this area and all referrals for community teams in the Dunfermline and West Fife area should be routed via PACT.

Limited data was available for the time period April 2005 – March 2007 and Table 4 provides a summary of descriptive statistics from the PACT dataset.

□ **NB:** These calculations are based on figures provided in Table 1 and 2, published by the General Register Office for Scotland in 2006. As these figures are based on estimates of future populations, they can only provide a guide and approximation of the future populations of Scotland and Fife.

Table 4: Summary statistics for PACT dataset, April 2005 – March 2007			
	2005/2006	2006/2007	Total
Total number of referrals	1261	1681	2942
Number of records without date of birth	3 (0.2%)	2 (0.12%)	5 (0.17%)
Number of referrals under the age of 65*	206 (16%)	234 (14%)	440 (15%)
Total number of referrals aged 65 and over*	1052 (83%)	1445 (86%)	2947 (85%)
Age range *	65 – 103	65 – 104	65 - 104
Gender distribution (M:F)	32%: 68%	35%: 65%	33.5%: 66.5%
* The data provided by PACT did not include the date when the client was referred to the PACT service therefore an accurate age could not be calculated. Instead, a referral date half way through the financial year (1 st September) was used as the date of referral to allow an estimated age at referral to be calculated. Therefore all analyses based on PACT data use an estimated age.			

Table 5 shows the age and gender distribution of the clients referred through the PACT service. This data shows that the majority of clients referred through the PACT service are females aged 75 or over.

Table 5: Age*/gender distribution of clients aged 65+ referred through PACT service, April 2005 - March 2007							
Age Band*	2005/2006				2006/2007		
	Male	Female	Missing	Total	Male	Female	Total
65-74	92 (9%)	152 (14%)	-	244 (23%)	115 (8%)	196 (14%)	503 (35%)
75-84	166 (16%)	333 (32%)	-	499 (47%)	245 (17%)	386 (27%)	311 (22%)
>85	79 (8%)	229 (22%)	1 (0.1%)	309 (29%)	140 (10%)	363 (25%)	631 (44%)
Total	337 (32%)	714 (68%)		1052 (100%)	500 (35%)	945 (65%)	1445 (100%)
* The data provided from PACT did not include the date when the client was referred to the PACT service therefore an accurate age could not be calculated. Instead, a referral date half way through the financial year (1 st September) was used as the date of referral to allow an estimated age at referral to be calculated. Therefore all analyses based on PACT data uses an estimated age.							

As the PACT service acts as a point of referral to different community teams in the Dunfermline and West Fife area, the data was analysed to identify where the referrals originate from. Table 6 provides a breakdown of the various sources of referrals to the PACT service and show that the majority of referrals came from Occupational Therapists, Physiotherapists and GPs.

Intermediate Care Needs Assessment: Final Report

It is also noted that the Fife Falls Response Service were responsible for 18.3% of PACT referrals in 2006 – 2007, increased from 3.5% in 2005-2006.

Table 6: Source of referrals to PACT service for people aged 65+, April 2005 – March 2007				
Referrer	2005/2006		2006/2007	
	Total	%	Number	%
Unknown	29	2.8	5	0.3
Social Worker	15	1.4	11	0.8
Self-Referral	0	0.0	17	1.2
Community	19	1.8	22	1.5
A&E	6	0.6	24	1.7
Home Care Manager	45	4.3	30	2.1
Integrated Response Team	11	1.0	39	2.7
Consultant	52	4.9	40	2.8
District Nurse	30	2.9	55	3.8
Other	40	3.8	59	4.1
Fife Falls Response Service	37	3.5	264	18.3
Ward staff	113	10.7	72	5.0
Physio	158	15.0	220	15.2
GP	248	23.6	278	19.2
OT	249	23.7	309	21.4
Total	1052	100	1445	100

In order to understand the medical reasons people were being referred for support from community teams, the PACT data was analysed to identify the main diagnosis for the client. Table 7 describes the different diagnoses for the clients referred via PACT to community teams and identifies the main reasons as Medical, Neurological, Falls, Mobility and Orthopaedics.

Table 7: Main diagnosis of clients aged 65+ referred through the PACT service, April 2005 – March 2007				
Main Diagnosis	2005/2006		2006/2007	
	Number	%	Number	%
Positive Steps Referral	2	0.2	0	0.0
Respiratory	6	0.6	0	0.0
Falls + Cancer	1	0.1	0	0.0
Falls + Ortho	2	0.2	0	0.0
Unknown	4	0.4	2	0.1
Cancer	3	0.3	14	1.0
Other	32	3.0	15	1.0
Surgical	60	5.7	49	3.4
Neurological	166	15.8	129	8.9
Medical	107	10.2	149	10.3
Falls	167	15.9	405	28.0
Mobility	234	22.2	380	26.3
Ortho	268	25.5	302	20.9
Total	1052	100	1445	100

The PACT data was analysed to identify the various community teams that are referred to via the PACT service, and thus identify those teams that may be providing intermediate care services. Table 8 provides details of those teams referred to via the PACT service between April 2005 and March 2007. From these results, it can be seen that the majority of referrals via the PACT service between April 2005 and March 2007 were for the Community Rehabilitation Team, the Community Physiotherapy Team and the Integrated Response Team for West Fife.

Table 8: Teams referred to via the PACT service for people aged 65+ , April 2005 – March 2007						
Team	2005/06		2006/07		Total	
	Number	%	Number	%	Number	%
Unknown	4	0.4	1	0.1	5	0.2
Parkinson's clinic	0	0.0	13	0.9	13	0.5
Care at home	16	1.5	42	2.9	58	2.3
None (Inappropriate referral)	35	3.3	39	2.7	74	3.0
Intermediate Care Bed	49	4.7	40	2.8	89	3.6
Community Rehabilitation Team	151	14.4	382	26.4	533	21.3
Integrated Response Team	317	30.1	364	25.2	681	27.3
Community Physiotherapy Team	480	45.6	564	39.0	1044	41.8
TOTAL	1052	100%	1445	100%	2497	100%

Single Point of Access (SPOA)

The “SPOA” dataset is collected by the Single Point of Access service in the Glenrothes and North East Fife area. Like the Point of Access for Community Teams in the Dunfermline and West Fife area, the SPOA service acts as a gateway for all referrals to community teams in this area and all referrals to community teams in the Glenrothes and North East Fife area should be routed through the SPOA service.

As the SPOA service only began in late August 2007, data is only available from that time to March 2008. Table 9 provides a summary of descriptive statistics from the SPOA dataset.

Table 9: Summary statistics for SPOA dataset, 27th August 2007 – March 2008*

Total number of referrals	1082
Number of records without date of birth	73 (6.7%)
Number of referrals under the age of 65	123 (11.4%)
Total number of referrals aged 65 and over	886 (81.9%)
Age range	65 – 99
Gender distribution (M:F)	37% Males: 63% Females
* In the case of referrals directly to clinical teams, only limited data is provided for recording on the SPOA system.	

Table 10 shows the age and gender distribution for the clients referred through the SPOA service between August 2007 and March 2008. This data shows that, as for the PACT service, the majority of clients being referred via SPOA are females aged over 75.

Table 10: Age/gender distribution of clients aged 65+ referred through SPOA, 27th August 2007 - March 2008

Age Band	Male	%	Female	%	Total	%
65-74	84	9.5	94	10.6	178	20.1
75-84	162	18.3	230	26.0	392	44.2
>85	83	9.4	233	26.3	316	35.7
Total	329	37.1	557	62.9	886	100

Data available from SPOA identified the number of people who had been referred through the service more than once. Table 11 provides details of this and shows that over 30% of clients being referred through SPOA have used the services accessed via SPOA on more than one occasion, and ten individuals have used the services accessed via SPOA on more than three occasions.

Table 11: Number of clients aged 65+ referred through the SPOA service on more than one occasion, 27th August 2007 – March 2008				
Total SPOA referrals	Number of clients	Total referrals	% of clients	% of total referrals
1	555	555	80.2	62.6
2	100	200	14.5	22.6
3	27	81	3.9	9.1
4	6	24	0.9	2.7
5	2	10	0.3	1.1
6	1	6	0.1	0.7
10	1	10	0.1	1.1
Total	692	886	100	100

The data available via SPOA provided details on the general reason for referring a client on to community teams. This data was analysed to gain an insight into how community teams are being utilized overall. Table 12 provides details of this analysis and shows that there are two main reasons for accessing community teams via the SPOA service: Supported Discharge and Routine Rehabilitation.

Prevention of Admission is listed as the main reason for accessing community services via SPOA in only 8.4% of cases. The data also shows that 12.9% of referrals recorded by SPOA are not actually routed by SPOA i.e. the details of the referral are recorded for information purposes only – the actual referrals have been sent direct to the community team in question and so limited data is available in these instances.

Table 12: Overall reason for accessing services for people aged 65+ referred via SPOA, 27th August 2007 – March 2008		
Reason	Number	%
Fife Falls Response Service	13	1.5
No info	16	1.8
Inappropriate	22	2.5
Prevention of admission	74	8.4
Not routed via SPOA	114	12.9
Supported discharge	216	24.4
Routine rehabilitation	431	48.6
TOTAL	886	100

As for the PACT data in Dunfermline and West Fife, the SPOA data was analysed to identify the staff groups who use SPOA to access community services in the Glenrothes and North East Fife area. Table 13 provides details of the various sources of referrals to the SPOA service and show that, as for the PACT service, the majority of referrals came from Occupational Therapists, Physiotherapists and GPs. In addition, the Fife Falls Response Service were responsible for 12.6% of all referrals through SPOA in this time.

Table 13: Source of referrals for people aged 65+ to SPOA service, 27th August 2007 – March 2008

Referrer	Number	%
Specialist Nurse	9	1
Integrated Response Team	19	2.1
Other	20	2.3
Consultant	24	2.7
Social Work	27	3
District Nurse	53	6
Ward Staff	58	6.5
Unknown	83	9.4
Physiotherapy staff	86	9.7
Fife Falls Response Service	112	12.6
Occupational Therapist	121	13.7
GP	274	30.9
Total	886	100

When the main diagnosis for the clients being referred to community teams via the SPOA service were analysed, the findings were similar to those for the PACT service: the majority of clients had a diagnosis of Medical, Orthopaedics, Mobility or Falls.

In the case of “Neurological” being the main diagnosis, this only accounted for 5.3% of clients referred via SPOA as opposed to approximately 10% referred via the PACT service. Table 14 provides details of the main diagnosis for the clients referred via SPOA between 27th August 2007 and March 2008.

Table 14: Main diagnosis of clients aged 65+ being referred through the SPOA service, 27th August 2007 – March 2008

Main diagnosis	Total	%
Surgical	11	1.2
Cancer	14	1.6
Other	15	1.7
Inappropriate	17	1.9
Neurological	47	5.3
Medical	102	11.5
Ortho	126	14.2
Unknown	182	20.5
Mobility	184	20.8
Falls	188	21.2
Total	886	100.0

The SPOA data was analysed to identify the various community teams that referred to via the SPOA service, and thus identify those teams that may be providing intermediate care services. Table 15 provides further details of those teams referred to via the SPOA service between 27th August 2007 and March 2008.

From these results, it can be seen that there were a total of fifteen community based teams who were accessed via the SPOA service, as opposed to six teams accessed via PACT. This reflects the differences in the community services provided in the different areas – Dunfermline and West Fife does not have community hospitals whilst Glenrothes and North East Fife has several.

Through analysing the data provided by the SPOA and PACT services, a total of twenty one different teams were identified. Through supporting discharge, providing rehabilitation services and preventing admission, each of these teams could be classed as providing intermediate care services across Fife.

Table 15: Teams referred to via the SPOA service for people aged 65+, 27th August 2007 – March 2008		
Team referred to	Number	%
Netherlea Domiciliary Physiotherapy	65	7.3
Netherlea Domiciliary Occupational Therapy	10	1.1
Adamson Occupational Therapy	23	2.6
Adamson Falls Response	30	3.4
Adamson Domiciliary Physiotherapy	66	7.4
Adamson Integrated Response Team	69	7.8
St Andrews Hospital Occupational Therapy	30	3.4
St Andrews Falls Response	32	3.6
St Andrews Domiciliary Physiotherapy	69	7.8
St Andrews Integrated Response Team	69	7.8
St Andrews Hospital Physiotherapy	122	13.8
Glenrothes Falls Response	57	6.4
Glenrothes Domiciliary Physiotherapy	74	8.4
Glenrothes Community Rehabilitation Team	68	7.7
Central Integrated Response Team	66	7.4
Inappropriate Referral	27	3
Unknown	9	1
TOTAL	886	100

Data from Integrated Response Teams

From the teams identified through the analysis of PACT and SPOA data, the Integrated Response Teams from the Dunfermline & West Fife and Central Fife areas provided data for further analysis.

NB: It should be stressed that this analysis should not be used for comparative purposes of IRT services within Fife. These teams are different in terms of size, composition, location and the population which they serve and so comparison is not appropriate. This analysis is shown for descriptive purposes only.

Dunfermline & West Fife Integrated Response Team (D/W FIFE IRT)

The D/W Fife IRT received an average of 422 referrals each year from April 2005 to March 2008, of which an average of 233 (74%) were accepted.

Reasons for not accepting referrals included the referral being inappropriate, the patient becoming unwell, the patient only requiring home care services and the patient or their family refusing IRT input.

The gender distribution of patients accepted by D/W Fife IRT reflected the general age distribution of the referrals via the PACT and SPOA service i.e. approximately 70% females to 30% males.

The age distribution also reflected that of the referrals received by PACT and SPOA in that the majority of clients were aged 75 and over.

The majority of referrals to D/W Fife IRT came from wards in QMH and in particular from Wards 5, 6, 13 and 14. Referrals were also received from a variety of other sources including Astley Ainslie Hospital in Lothian, Stracathro Hospital in Tayside, Falkirk Royal Infirmary and Stirling Royal Infirmary in the Forth Valley area.

An average of 6% of all referrals accepted by D/W Fife IRT were for prevention of admission whilst and average of 91% were for discharge support. Data also showed "Carer Support" and "Delayed Discharge" as being alternative reasons for a referral being received (and accepted) by D/W Fife IRT. These figures reflect that the D/W Fife IRT was originally established to support discharge from hospital.

Central Fife Integrated Response Team (Central IRT)

The Central Fife IRT received an average of 433 referrals each year from April 2005 to March 2008, of which an average of 255 (82%) were accepted. Reasons for not being accepted included the patient being medically unfit for discharge, the patient requiring long term care, the referral being inappropriate or the patient declining IRT support. There were also a few occasions where the referral could not be accepted due to the IRT service working to full capacity.

The gender distribution of referrals accepted by Central Fife IRT reflected that found with D/W Fife IRT, SPOA and PACT data i.e. approximately 70% females to 30% males. However, in the year 2005/06, the gender distribution was 64% females to 36% males.

The age distribution also reflected that found with D/W Fife IRT, SPOA and PACT in that the vast majority of patients referred (and accepted) to Central Fife IRT were aged 75 or over.

The majority of referrals to Central Fife IRT came from the Victoria Hospital Kirkcaldy and, in particular, Wards 6, 12, 15 and 16. Wards 13 and 14 of QMH comprised an average of 8% and 7.5% of all referrals to Central Fife IRT. Referrals were also received from Ninewells Hospital in Tayside and, as

An average of 96% of all referrals accepted by Central IRT were for discharge support whilst 4% were for prevention of admission. Data also showed "Carer Support" as being a reason for a referral being accepted by Central IRT. Again, these figures reflect that the Central Fife IRT was originally established to support discharge from hospital

Further data was provided by D/W Fife and Central Fife IRTs which could be analysed to explain the types of services provided by these teams. There was not enough time in this present project to undertake such an analysis but this data could prove valuable in starting to determine what an intermediate care service could provide.

6.3.4 Key findings from quantitative analysis

The key findings from the quantitative analysis are as follows:

- The population of people aged 65 and over in Fife is projected to increase from 59840 in 2006 to 83850 in 2021 – an increase of 40.1%.
- In particular, the number of males aged 85 and over is projected to increase by approximately 115% from 2027 in 2006 to 4365 in 2021.
- If current rates of admission of older people to hospital are applied to population projections, there is the potential for 9055 people aged 65 and over to be admitted to hospital as an emergency in 2021 – an increase of 2593 compared to 2006.
- The increase in the number of people aged 65 and over in Fife in coming years, and the potential increase in the number of emergency admissions to hospital, has significant implications for service provision in Fife.
- Local data showed that there are a variety of teams in Fife providing support to people being discharged from hospital. To a much lesser extent, these teams provide support in order to prevent admission to hospital. The majority of clients currently being referred to these services are female and aged 75 and over. Given the high rate of emergency admissions for males aged 85 and over in Fife, alongside the projected increase in this age group, it would be useful to explore the reasons for this difference. For example it may be partly related to women's life expectancy being greater than men's and therefore being more likely than men to be living alone. Consideration should be given to ensuring that males aged 85 and over have appropriate access to these services according to need.
- The majority of referrals to community teams come from physiotherapy staff, occupational therapy staff, GPs and Fife Falls Response Service.
- The majority of main diagnoses for people referred to community teams are medical, neurological, mobility, orthopaedics and falls.
- The majority of referrals through the PACT and SPOA services are for Community Rehabilitation Teams, Integrated Response Teams and Community Physiotherapy Teams.
- In the Glenrothes & North East Fife area, more than 30% of people referred via the SPOA service will be referred more than once. In some instances, there have been people referred up to ten times, often for similar services.
- The majority of referrals to Integrated Response Teams in Dunfermline/West Fife and Central Fife come from hospital staff which reflects the fact that the majority of referrals are to support discharge.

7 Discussion

Intermediate care services in Fife

The results from the qualitative and quantitative analysis show that there are a variety of services providing intermediate care currently available in the Fife region. Each has its own team composition, set of eligibility criteria and geographical boundaries. The majority of services are aimed at supporting discharge.

This echoes the evidence from the published literature and highlights that the challenges associated with providing intermediate care services are not unique to one professional group or to one geographic region.

Definition of intermediate care

The diversity in intermediate care teams in part reflects the general vagueness around the definition of intermediate care. In England, national policy outlines what intermediate care services should provide but evidence shows that existing services are being re-badged and called intermediate care. In Scotland, the term “intermediate care” is used in several key policy documents but without a concrete definition and indeed without concrete guidance on how an intermediate care service or function should be developed.

In April 2007, the National Outcomes for Community Care⁵⁶ were published and mentioned intermediate care in the discussion around developing Outcome Measure OP6: “Number of patients waiting more than six weeks to be discharged into a more appropriate setting”. The document proposed that a future measure around intermediate care should be considered. It did not provide a definition of what intermediate care was or how it could be measured.

The broad concepts of “preventing unnecessary admissions to hospital” and “supporting discharge from hospital” were used in order to provide some focus for this needs assessment of intermediate care services in Fife but further discussion should be undertaken to reach agreement of the teams and services that should or should not be classed as serving this function.

Consideration should be given to whether services provided by community based teams providing, for example rehabilitation physiotherapy or occupational therapy should constitute intermediate care. Similarly, consideration should be given to some of the teams/services provided for specific conditions such as cardiac rehabilitation, stroke rehabilitation or falls response teams – should these be included in future work on intermediate care?

In order to fully understand the facilities which might be available to support intermediate care services, there should be discussion around which beds and wards throughout Fife can be accessed by intermediate care services. At the present time there are a variety of Care of the Elderly beds, rehabilitation GP beds across Fife and discussion around whether these beds are appropriate to provide intermediate care should be progressed.

Preventing admission or supporting discharge

The models in Fife, in the main, provide support to people in their home following discharge from hospital. This reflects what is happening elsewhere in the country. There are few initiatives which look solely at prevention of admission to hospital (e.g. Fife Falls Response Service, Rapid & Discharge Teams), possibly due to the emphasis of recent times placed on reducing delayed discharge figures. It should be noted that the qualitative work indicated that the North East Fife Integrated Response Team play a key role in preventing admission to hospital in this area. Unfortunately, quantitative data was not available to look further at this.

The work undertaken by the British Geriatric Society²⁰ identified three key stages where intermediate care could benefit older people: managing crises at home or in the community, managing crises at the (acute) door and post-acute support. The paper highlighted previous work that showed between 5 and 29% of older people presenting as emergencies had post-acute care needs and could therefore be streamed into intermediate care services.

The national evaluation of intermediate care services for older people in England highlighted the increased quality of life outcomes of admission avoidance schemes compared to supported discharge. It also highlighted that the published literature contains relatively little evidence on the effectiveness or cost effectiveness of admission avoidance schemes. Nonetheless, consideration should be given to how such initiatives can be developed further in Fife.

Coordinated approach

Intermediate care is being provided by teams across Fife. However, teams can sometimes work in isolation, have overlapping remits, eligibility criteria etc. In order to improve services, a more coordinated joint working approach should be considered.

There are several models in the published literature which emphasise the benefits of coordinated joint working between health and social care services. These models are similar to the single point of access models currently in place in Fife but also include an overall clinical coordination role to ensure the patient is routed appropriately.

This would mean a change from the current system where the person requesting the referral decides where the referral should go to, to a system where the clinical coordinator, with knowledge of the various teams, eligibility criteria and capacity, would route the patient.

Such a coordinated approach has several implications:

- There would be more clarity around the various services providing intermediate care in Fife
- There would have to be clear remits for each of the various teams/services

- There would have to be clear, jointly developed eligibility criteria for each team/service
- Consideration would have to be given to the resources required to ensure this coordinated approach is available 24 hours a day if a continuum of care is desired

Such a change in service organisation would be a major undertaking if it were to be carried out on a Fife-wide basis. However, smaller areas of work could be progressed in the various localities in order to move forward. A starting point could be building on the work undertaken through this needs assessment and carrying out further mapping of services in each of the LMU or CHP areas in order to identify areas of overlap.

This model of joint working would require buy-in from the various stakeholders involved, including acute hospital based staff, community based staff and social care staff. This point is especially relevant given that almost 13% of referrals to community teams recorded in the SPOA database were sent directly to the team being referred to i.e. not via the SPOA service. Anecdotal evidence also suggests that a significant percentage of referrals via the PACT service went directly to the teams being referred to.

Decision making processes

One of the original reasons for undertaking this piece of work was to identify whether decisions are being made too quickly, and in inappropriate settings, about whether an older person has the potential to rehabilitate. This, in turn, was linked to whether an older person was transferred too quickly and without sufficient opportunities for rehabilitation and re-ablement to a care home setting following discharge.

The evidence from qualitative interviews with service providers suggested that such decisions are only undertaken following a full multi-disciplinary assessment and that, in the vast majority of cases, the decision for a person to go to a care home was the correct decision.

However, the views of older people who experienced such a move to a care home could not be sought in the timeframe of this work. Attempts to establish other sources of information around this were unsuccessful. Current projects underway in health and social care teams across Fife, alongside the work being undertaken by the JIT team on Digital Stories might provide valuable information on the patients' perspective.

Data to demonstrate intermediate care

One of the main challenges in this piece of work was concerned with accessing appropriate information around intermediate care services. This is in part due to the lack of a definition of what intermediate care is but is also due to data not being collected for several of the services/teams providing intermediate care. Where data is collected, it can be difficult to use in comparative analysis due to different data being collected between services.

In addition, data that is collected often refers to outcome indicators for services and not whether the personal goals of the patient have been met. This reflects the emphasis on demonstrating effective services and meeting targets. However, data reflecting the person-centred goals would be valuable in assessing whether the patient felt the services they received were of benefit.

Evaluation of intermediate care

Evaluation of intermediate care models remains a challenge. When data is collected, this can provide valuable information about how a service is being used. However, the challenges associated with evaluating intermediate care services was a recurring theme throughout the published literature. A recent meeting of the JIT Intermediate Care Learning Network emphasised the lack of evaluation tools available and work is progressing to remedy this.

The link between delayed discharges and intermediate care services

A great deal of effort has gone into reducing delayed discharges in Fife and, as of April 2008, the government target of having no-one being delayed over six weeks was met.

Additional funds were provided to assist in meeting the national target and several interviewees mentioned delayed discharge funding along with “Winter Initiative” funding. These funds often went towards increasing the capacity of rehabilitation care assistant (either through additional hours or posts) within existing teams, often resulting in teams being able to increase their caseload. What role did this increase in the capacity of teams providing intermediate care play in reducing the delayed discharge figures in Fife?

Further discussion around how teams providing intermediate care services can facilitate timely discharge from hospital would help inform future developments in this area.

8 Recommendations

The recommendations from this needs assessment are as follows:

- Intermediate care can be provided by a variety of services including health, social care and housing. All further dialogue around intermediate care if Fife should be undertaken in partnership with representatives from each of the appropriate services and stakeholder groups. The views of older people in Fife should also be taken into account.
- For the purpose of this needs assessment, the concepts of “preventing unnecessary admissions to hospital” and “supporting discharge from hospital” were used to broadly define intermediate care. It is recommended that the Older Peoples SIG uses these concepts as the basis for developing a Fife wide definition of intermediate care at a strategic level.
- The strategic definition of intermediate care should be used at a local level to provide guidance in undertaking a full mapping of local services currently providing intermediate care.
- Given the evidence around the potential benefits for patients (improved quality of life, maintaining confidence) and for services (less demand on beds, lower costs); more emphasis should be placed on developing initiatives that support the prevention of unnecessary admission to hospital. Discussion around what constitutes an appropriate geriatric assessment should be part of this work.
- It is recommended that a core dataset of key indicators is collected by each team providing intermediate care. This would allow meaningful analysis to be carried out to provide valuable information on the services provided by the teams and the needs of the service users.
- Given the number of different teams across Fife providing potentially similar services, consideration should be given to a more coordinated approach at a local level, possibly developing the PACT and SPOA model to include a clinical coordinator role to ensure referrals were appropriately routed.
- Further dialogue around the role intermediate care services can play in ensuring timely discharge from hospital is needed in order to maximise potential benefit.
- Links with local and national projects looking into the experience of older people when being discharged from hospital should be established/maintained in order to ensure learning points are shared.
- Further consideration should be given to the role the independent care sector and housing can play in intermediate care services in Fife.
- Links should be maintained with the Intermediate Care Learning Network, facilitated by the Joint Improvement Team, in order to learn from the experiences of other areas in developing intermediate care services.

9 Acknowledgements

The authors would like to thank the Steering Group for their help and guidance in overseeing the work of this needs assessment. The Steering Group membership is as follows:

Heather Kenney	Strategic Change Manager, NHS Fife
Rona Laing	Social Work Service Manager, Fife Council
Heather Lawrie	Senior Nurse, Older Peoples Services, Glenrothes & NE Fife Community Health Partnership
Jean Leslie	Acting Head of OT Services, Operational Division
Fiona McKenzie	Local Clinical Services Manager, Kirkcaldy & Levenmouth Community Health Partnership
Gordon McLaren	Consultant in Public Health Medicine, NHS Fife
Sue Pound	Consultant Geriatrician, NHS Fife
Pauline Small	Head of Nursing, Dunfermline & West Fife CHP
Rachel Strachan	Assistant Director of Clinical Delivery, NHS Fife

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10 Appendices

- Appendix 1:** Distribution List: Intermediate Care Needs Assessment - Draft Report for Consultation
- Appendix 2:** Feedback from consultation exercise, June-August 2008
- Appendix 3:** Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007

Appendix 1

Distribution List: Intermediate Care Needs Assessment - Draft Report for Consultation

Vicki Irons, General Manager, Glenrothes & North East Fife CHP
Susan Manion, General Manager, Dunfermline & West Fife CHP
George Cunningham, General Manager, Kirkcaldy & Levenmouth CHP
Fiona Mackenzie, Chair, Kirkcaldy & Levenmouth LMUs
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Jessie Watt, Coordinator, Fife User Panels
John McKendrick, Coordinator, Fife Elderly Forum
Mary Stewart, Centre Manager, Fife Carers Centre

Appendix 2: Feedback from consultation exercise, June-August 2008

General Feedback

- Report looks very good and should be a useful reference for the future. However, a model of where intermediate care fits in the greater scheme of things is missing.
- We found this to be a very comprehensive and well structured report. It reflected the complexity of the subject and gave clarity around evidence available and the emerging themes from both the qualitative interviews and the quantitative analysis.
- We feel this is a very comprehensive assessment of the current situation that should provide clear direction within the partnership. This will support more confident plans to be developed particularly in the short to medium term in respect of Intermediate Care.
- The report would benefit from the inclusion of a clear definition of intermediate care.
- Place more emphasis on what is meant by the “strategic definition of intermediate care”. Definition on Page 19 should be used - it may require to have brackets removed and prevention of hospital admission and supporting discharge, stated as a final sentence to illustrate both hospital and community perspectives.
- The report is extensive and provides a good synopsis of services provided across Fife that could be defined as intermediate care. However, this in isolation does not provide an extensive needs assessment of intermediate care. There is little evidence within the report that would allow us to come to some agreement over the impact of the current service provision, or the demand for intermediate care services in the future.
- There remains a gap in the definition of a rehabilitation model for older people and although the report acknowledges the work underway around the rehabilitation framework it would be very difficult to agree a model for intermediate care without defining what rehabilitation means for older people
- The report acknowledges that service provision across CHP areas is different and in fact very different in West Fife which has no community hospital. The role of the LMU's is to agree development of service and alongside this there is an older people group in West Fife which we would expect to take forward any debate in terms of the health part of the model. Further consultation is therefore required on a Fife wide approach to service development in this area. In addition the report does not appear to acknowledge the impact of the service change on the VHK site in 2012/13 and how this will affect service models.
- We note that while the older people via Fife User Panels and Elderly Forums articulated the need to have individualised care, this is not necessarily reflected in the professionals approach. It appears we seem service driven, within a complex arrangement of teams that only the providers understand (sometimes!).
- ‘Rosy view’ of how things could be , the report does not quite capture the actual reality, e.g. local knowledge essential to navigate the services
- There is geographical/CHP inequity of availability of resources. (e.g. differences in CRT provision)
- Both anticipatory care and discharge planning needs the provision of fast flexible responsive services both in the community and in hospital.

Appendix 2: Feedback from consultation exercise, June-August 2008 (ctd)

<p>Mapping of services</p> <ul style="list-style-type: none"> • Aware this mapping is currently ongoing within each of the CHP's • Under key recommendations in the third bullet point, we would suggest that a full mapping of local services is not what should be recommended, but based on the strategic definition of Intermediate Care, partnerships at a local level should undertake to clearly define the range of Intermediate Care Services, where they are, what they do and how they link from a patients perspective. This is perhaps slightly different from mapping, which we have done in the past, with little effect.
<p>Development of a core dataset</p> <ul style="list-style-type: none"> • A core data set would need to be led Fife wide. • We are particularly supportive of the recommendation re core data set, and that the independent sector should be involved in any future discussions on Intermediate care
<p>Coordination of intermediate care services</p> <ul style="list-style-type: none"> • Agree with coordinated approach but this needs to be flexible enough to allow requests for one specific service if it meets the required criteria, e.g. community physio not CRT • It would be beneficial to have a more integrated approach for community teams particularly in some areas. It was felt that there are system in place and not a need for a clinical co-ordinator role • There should be more joint working between council and health with strict parameters laid down and adhered to, to prevent the teams becoming saturated and dysfunctional. If everything went to strict time scales flow would/should happen.
<p>Prevention of admission</p> <ul style="list-style-type: none"> • One team should be responsible for preventing admission and pulling patients from hospital back into the community. • RAD also facilitate discharge from AMAU, not just prevention of admission from A/E. RAD can provide figures from 2006 audit, as number of bed days saved for prevention of admission • Early identification of at risk patients allows assessment and medical and social care needs to be agreed and services put in place. This includes aspects of long term condition management such as cardiac and pulmonary rehabilitation and palliative care (cancer and non-cancer). This reduces the need for crisis care provided by intermediate care which may escalate to hospital care.

Appendix 2: Feedback from consultation exercise, June-August 2008 (ctd)

Discharge Planning
<ul style="list-style-type: none"> • Can also occur from community teams providing intermediate care and anticipatory care as well as hospital. It is, in a way, similar to or overlaps with anticipatory care and if done properly reduces readmissions and admissions. • Some concern that at present the focus is on getting the patient out of hospital not on the patient's needs. • Need to ensure good communication with all partners within NHF Fife and Fife Council to improve communication and allow a more co-ordinated approach to care. To have a more co-ordinated approach at discharge from hospital is essential.
Social work involvement
<ul style="list-style-type: none"> • No patients are waiting more than 6 weeks for SW assessment. In fact, Fife has reported no delayed discharges over 6 weeks for past few months. • There should be earlier intervention by S.W. both within the Community and Hospital discharge teams - hospital pending lists are about a 4 week pick up time in the central CHP but initial inquiry/assessment made by a duty worker. Community social work pending lists are very extensive.
Integrated Response Teams
<ul style="list-style-type: none"> • IRT's do not receive 'self-referrals'. Some people are at home when referred but this does not come from themselves but from other professionals e.g. Social work, GP, District Nurse.
Dementia
<ul style="list-style-type: none"> • Dementia patients show such a huge variety of behaviours that it is not always possible for them to be cared for in main stream services- there should be specialised care for a large proportion of these patients. • Regarding "Intermediate care" Services for patients with dementia, taking the very broad definition used in a way I think I could describe the whole Old Age Psychiatry service (apart from inpatient beds) as providing this. However there are also more specialist teams (EAST & CAST) in addition to the usual but they don't cover all areas and I would suggest their remit is much more to do with admission prevention unlike many of the other teams. • Given resources available and the complexity of the patient's needs "specialist dementia intermediate care teams" are never going to be able to accept more than a small proportion of the total population of patients with dementia who will continue to be managed within mainstream services. My impression (perhaps wrong) is that there is still a fair amount of concern amongst colleagues in such teams as to whether they have the requisite skills and available support to manage these patients. This of course takes us back to the topic of effective coordination and liaison between services. • There needs to be more access for intermediate care services/diagnosis for people who have not yet had a formal diagnosis of dementia. The diagnosis is the gateway to referral and can leave people blocking beds or being left vulnerable when other services could kick in. • Psychiatric liaison nurse role not mentioned – this is not available to A/E or AMAU • OTs (Operational Division) are planning to improve links with our OT colleagues in Elderly Mental health. RAD team do have good links already.

- Issue around lack of provision for a full dementia screening to be carried out. Patients are admitted to acute, turned around quickly and perhaps would benefit from a dementia screening to prevent further unnecessary admissions. Less stigma towards the dementia label!!

Appendix 2: Feedback from consultation exercise, June-August 2008 (ctd)

Decision making processes: Discharge

- The statement that staff are “too risk averse” is much too understated. Many patients are deemed suitable for nursing home too early in their journey and would benefit from assessment & rehab before the decision is made. However pressure on beds in the acute wards leads many clinicians to apply pressure to the MDT/SW to place the patient before a full and final assessment has been completed.
- Very often the decision for the patient to go to alternative care is made as a unilateral decision at the point that the acute medical treatment is complete. Unfortunately the time frame attached to the SW referral process isn’t conducive to patients being given adequate time to make the decision about where they wish to live.
- Perhaps another aspect of Intermediate Care is the availability of information for both Staff/carers and patients in order that informed decisions about the care can then be made.
- Re timescales available -perhaps the gap re patient views should be more strongly stated, in that it did not allow involvement of older people who have been through the discharge process, therefore, findings it should be taken in this context.
- Issue around lack of support in patients own home to enable them to make the decision whether to remain there or go for alternative care.
- Should there be a further objective relating to “risk aversion” affecting needs assessment decision-making?

Professional roles/consequences for service users

- The role of rehabilitation care assistants and that of care assistants/nursing assistant is a very different one; it should also be borne in mind that the rehabilitation care assistants pay visits to the clients/patients in their own homes and very often cannot access any registered cover/support during these visits. In a previous organisation an issue arose around which organisation employs these carers, as further on in the development of the services, costs to the client became an issue as the carers were then employed by SW and charges were applied in the normal routine of SW charging: this then meant that this healthcare was not being delivered free at the point of delivery.

Home care services

- Mentioned within Social Work services and also in the discussion around the current difficulties. A need for a section on what they can provide, to illustrate their service
- Home Care Manager (HCM) role within IRT is different from HCM role within A/E and AMAU (Acute Medical Admissions Unit). IRT used to count bed days saved as Outcome measure. There is an impression IRT services are being blocked by referrers accessing Home Care due to difficulties with that service

- The assessments and the reassessments for home care are slow and cumbersome causing problems for discharging patients and can contribute to unnecessary admissions.

Appendix 2: Feedback from consultation exercise, June-August 2008 (ctd)

Housing
<ul style="list-style-type: none">• Housing difficulties - perhaps the council need to look at the individual assessments of patients in hospital and still renting their property when it is very evident that the patient will not be returning to their own home. With the 6 weeks allowed time for Delayed discharge this should speed up this process.(I know that we have had patients that are in Bield housing that have been referred for long NHS continuing care and their house cannot be given up. There maybe room for improvement to make this more efficient and still be legal. Relatives can be anxious about payment upkeep etc as their loved one care allowances have stopped.) There are waiting lists for these properties.
Community constraints
<ul style="list-style-type: none">• Lack of ownership. The need for more flexible hours in the community. Not Mon- Fri 0900-1700hrs syndrome.• Too many individual teams silo working. Communication constraints.• Teams becoming ineffective because they cannot transfer their patients over to main stream care.• Need for more Night link service, and this to be extended across Fife.• I'm not too keen on Care homes being used as I think Fife has enough community hospitals that could provide opportunities for intermediate care. G.P. beds exist and perhaps need to extend their role a bit more. Nurse and AHP led beds. More cohesion with Community staff and community Hospital roles. The purchase of nursing home beds may have to be looked at in the West where there are not any Community hospitals. This does have an effect trying to move transitional patients through the QMH.• More funding needed for Alzheimers Scotland as they deal with patients that have cognitive dysfunction post Stroke or other Brain assaults. Sometimes the lack of availability of this service could mean a patient cannot return to her/his own home.• It would be good to have a more simple holistic approach to care in the community and to have service responses more timeously.
Potential further work
<ul style="list-style-type: none">• The experience of older people being discharged to alternative care following a hospital stay - this piece of work should be undertaken at a later date to evidence the older person wishes.

Appendix 3: Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007

Name	The Links Unit, City Hospital, Aberdeen
Details	Nurse led unit with GP support. Offers assessment, investigation and treatment, rehabilitation, palliative and terminal care.
Services	Nursing, Physiotherapy, Occupational Therapy, Chiropody, Dietetics, Speech & Language Therapy, Dentistry
Referral route	Referral from Community via GP, extended Primary Care Team, AHP, Rapid Response Team. Also from Aberdeen Royal Infirmary or Woodend Hospitals.
Inclusion/Exclusion	Does not provide services for patients who: require specialised care, who have profound confusion, psychiatric, chronic alcohol abuse problems, who primarily require social/respite care
Evaluation	User satisfaction monitored via survey of Single Shared Assessment. Audit of services underway
Name	Kirklandside Hospital, Kilmarnock
Details	16 beds for "Step-down" service to speed up discharge from hospital. Time limited for max of 8 weeks
Services	MDT including discharge coordinator, rapid response services, GP, Nursing staff, Pysio, OT, Speech & Language Therapist, Dietitian, Social worker, Home care manager, Liaison health visitor, Community nursing staff. Medical cover provide by local GP practice.
Referral route	Over 60s who have health and social care need which requires intervention and support to enable increased level of independence. Must be medically stable, no longer requiring the service of an acute hospital and have realistic chance of rehabilitation (based on MDT assessment). Does not take people with multi-infarct dementia/Alzheimers
Inclusion/Exclusion	Supported by community hospiatls, rapid response services, hospital discharge services, integrate care teams, home care services, day care/day hospital services
Name	Smithfields Court, Aberdeen
Details	20 fully equipped apartments, temporary (4 - 8 weeks) period of rehabilitation in community setting. Set within existing sheltered housing complex.
Services	Provides personal programme of rehab delivered by physios, OTs, district nurses and rehab assistants.
Referral route	Referral via care managers, social workers, GPs, district nurses, hospital discharge coordinators, physios, OTs and frail elderly support team.

Appendix 3: Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007 (ctd)

Inclusion/ Exclusion	Services for people who are unable to return to, or remain in, their own homes following illness, accident or housing difficulties. Inc people discharged from hospital requiring further rehab prior to returning home, people with difficulties in own home who would benefit from short period of rehab, people considering a move to care home
Evaluation	User satisfaction monitored via survey of Single Shared Assessment. Audit of services underway
	Croft House, Aberdeen
	8 bedded Rehab and Assessment Pilot Scheme for physically frail or ill older people who do not require hospital admission but would benefit from limited rehab period to regain skills to return home. Also those who no longer need acute hospital care but need period of rehab in order to return home. Also for people who have the potential for rehab to enable them to remain in community and avoid/delay admission to residential care.
	Support of residential care staff, occupational therapists, physiotherapists, community nurses (on sessional basis). Also input from consultant geriatrician
	Referral via hospital discharge liaison staff, care managers, social workers, GP, Community Nursing Staff
	Priority given to delayed discharges or failed discharges. Will cater for people with mental health problems that are not severe or enduring
	User satisfaction monitored via survey of Single Shared Assessment. Audit of services underway
	David White Intermediate Care Unit, Saltcoats
	10 beds to provide intensive support and rehabilitation for people whose independence would be improved within a 6 - 8 week period
	Via acute and community hospitals (following surgery, fracture, infection etc) or from services in the community (district nurse, community care tea., GP etc)
	Evaluation focused on the improvement in independence of patients/clients/residents within 6-8 weeks, adherence to admission criteria, outcomes, lengths of stay, changes in levels of independence, levels of home care support pre/post admission, quality of care, level of patient/client satisfaction, inappropriate admissions, lack of availability of suitable placements
	"comparatively little information about the cost of care and the relative cost benefit of this type of service"

Appendix 3: Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007 (ctd)

	Up and About, Templeton House, Ayr
	7 beds for short residential programmes of therapy and rehabilitation for up to 6 weeks
	Via hospital staff, GPs, district nurses and social workers
	People aged over 60 who are medically stable and require a period of support before going home
	Mentions "100% of service users considered their discharge to be successful" but doesn't give details re how this was measured
	Ross Court Resource Centre, Galston
	10 beds, aims to support older people to remain independent in their community
	Includes lunch clubs, information and advice, day services, short term assessment/rehab facility. Partnership basis with all social care/health service providers inc GPs, District Nurses, Pharmacists, Dentists, Home carers, Social work services, Community Groups
	Wide inclusion criteria for residential admission
	The Glens, Edzell, Brechin, Angus/ Cairnie Lodge
	2 beds (The Glens) and 6 beds (Cairnie Lodge) available for Intermediate Care. Flexible arrangement allows commission of further beds. Planned outcome of maximising independence and enabling patients to resume living at home.
	Comprehensive Assessment followed by structured care plan involving active therapy, treatment and opportunities for recovery and rehabilitation. Time limited: 2 - 6 weeks.
	Short term respite available if primary carer is admitted to hospital to prevent inappropriate admission of cared-for person to acute hospital.
	Evaluation carried out looking at: cost in comparison to hospital care, number of acute bed days saved, changes in level of functional ability, medical input required, service users/family-carer satisfaction.

Appendix 3: Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007 (ctd)

	Eastwood, East Renfrewshire
	Focuses on prevention of admission, assessment and active rehabilitation. Links with Royal Alexandra Hosp to share patient info 1 week prior to admission or discharge
	It "may" include services for people with complex discharge requirements
	Leven Valley, East Renfrewshire
	Team responsible for the rapid assessment/ rehabilitation for older people to prevent admission to hospital. Also tracks patient through hospital to enable early complex discharge. Not residential-people admitted to hosp for complex investigations. Respite care/some rehab provided in residential nursing homes
	Services are patient centred including physiotherapy, occupational therapy, community psychiatric nursing
	Greater Glasgow
	Interdisciplinary Response & Intervention Service:
	Provides appropriate admission avoidance and early supported discharge via GP rapid response, discharge from A&E
	Provides figures but no evaluation
	Greater Glasgow
	Discharge & Rehabilitation Team :
	Provides early supported discharge from in-patient areas targeting vulnerable older people
	Provides figures but no evaluation

Appendix 3: Intermediate care initiatives identified from Joint Improvement Team Scoping Exercise, July 2007

	Greater Glasgow
	Outpatient/Home parenteral antibiotic therapy service
	Provides alternative to in patient care for patients requiring intravenous antibiotic therapy
	Provides figures but no evaluation
	Not specifically for older people
	Greater Glasgow
	Acute Hosp Homeless Liaison Service
	Provides structured link back to community services for homeless people attending/being admitted to hospital
	Provides figures but no evaluation
	Not specifically for older people

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