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Intermediate Care

Readiness to Scale

August 2013 report of a survey of Partnerships undertaken in April 2013

JIT is a strategic improvement partnership between the Scottish Government, NHS Scotland, CoSLA, the Third Sector, the Independent Sector and the Housing Sector

Intermediate Care in Scotland

Readiness to Scale

Background

''Maximising Recovery, Promoting Independence''- An Intermediate Care Framework for Scotland, describes a continuum of integrated services for assessment, treatment and support for older people and adults with long term conditions at times of transition in their health and support needs. Provided in the community, these services offer alternatives to emergency inpatient care, support timely discharge from hospital, promote recovery and return to independence, and prevent premature admission to long-term residential care.

Intermediate Care makes an important contribution to Reshaping Care for Older People and to building capacity and resilience for Unscheduled Care. Through Reshaping Care Change Plans and Joint Strategic Commissioning, all Partnerships are developing or enhancing aspects of Intermediate Care. NHS Boards are also developing local plans to improve the quality of Unscheduled Care. These plans aim to improve whole system flow and to build capacity for anticipatory and urgent care and support in hospital and in the community.

The JIT established an Intermediate Care Group in February 2013 to support partnerships to share learning, spread good practice and to scale up Intermediate Care. A first action for the group was to establish a baseline profile of Intermediate Care across Scotland.

Survey

Operational leads for the 32 Reshaping Care partnerships were asked to provide contact details for their local lead(s) for Intermediate Care and invite them to complete a short web based survey http://www.surveymonkey.com/s/intermediatecare.

The purpose of the survey was to provide a 'snapshot' of Intermediate Care as provided across Scotland at April 2013.

The survey aimed to:

- Describe the range of Intermediate Care services provided
- Explore perceived barriers and solutions for scaling up Intermediate Care capacity
- Identify themes for improvement support
- Signpost to examples of good practice

The questions did not seek detailed information on falls prevention and re-ablement services as these have been the subject of recent national surveys and published reports:

Survey and Case Studies of Re-ablement Activity in Scotland
Falls Report: Up and About or Falling Short?

Response

All partnerships responded, either individually or as a collated submission across a Health Board area (eg East Ayrshire, North Ayrshire and South Ayrshire partnerships). However not all partnerships answered every question.

Intermediate Care Lead

All partnerships identified and provided contact details for their local Intermediate Care lead.

Nominated leads have a range of backgrounds and include health or social care service managers, planners and leads for primary care, community nursing and Allied Health Professions (**Appendix 1**).

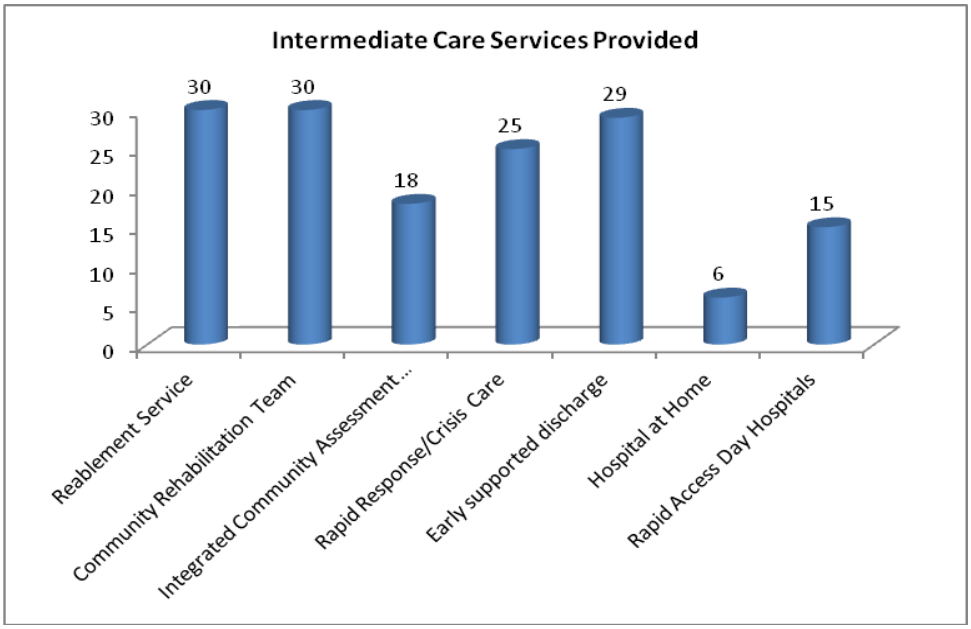
Range of Services Provided

Intermediate Care services such as Re-ablement, Community Rehabilitation Teams, Early Supported Discharge and Rapid Response / Crisis Care are now widespread (Figure 1), albeit tailored to the local context. For example, while Western Isles and Shetland do not report a formal reablement service or community rehabilitation team, they have other arrangements for providing support that is attuned to their local communities and geography.

Hospital at Home is a more recent innovation that is currently delivered only in North Lanarkshire, Fife, Moray, Angus, Highland and West Lothian.

Many partnerships reported that they are beginning to align and integrate different components of Intermediate Care - eg by establishing an integrated service that provides a continuum of rapid response, assessment, re-ablement and rehabilitation.

Fig 1



Access

Even the more established services are not yet available in all localities (Table 1).

Although some operate extended hours and over 7 days, in others gaps are generally covered by community nursing and out of hours services. For example, the Angus prevention of admission scheme takes referrals 9am - 10pm 7 days per week and the North Lanarkshire Community Assessment and Rehabilitation Service is piloting a 7 day service.

Table 1

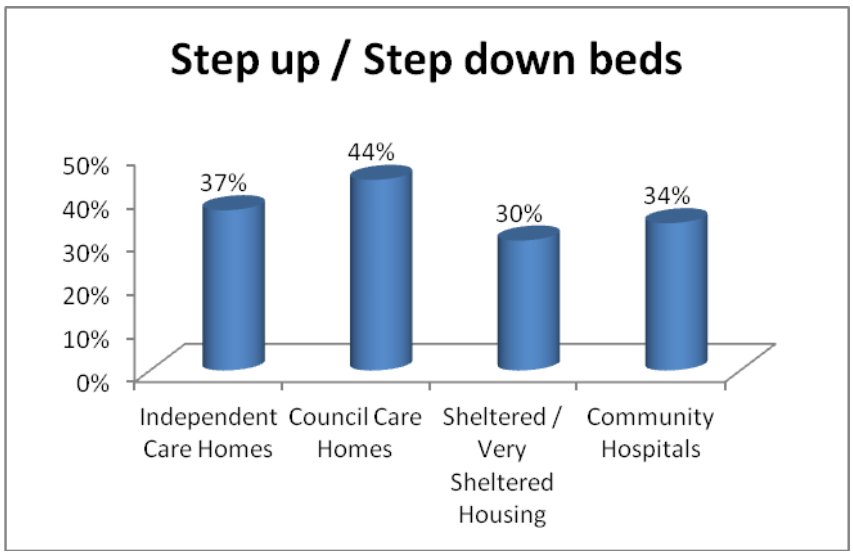
	Available in all localities	Available in some localities	Operates 7 days per week
Re-ablement Service	25	5	21
Community Rehabilitation Team	24	5	10
Integrated Community Assessment and Support Team	10	8	5
Rapid Response/Crisis Care	24	1	14
Early supported discharge	26	3	7
Hospital at Home	4	2	5
Rapid Access Day Hospitals	11	4	0

– extend provision to all localities and operate 7 days if appropriate

'Step- up / step - down' bed models

Intermediate Care is provided in the individual's own home where possible. For people who live alone or where their home may not be suitable, many partnerships now provide or contract step up / step down intermediate care in other community settings (Fig 2). These include council or independent sector care homes and housing with care facilities.

Fig 2



There is no consistent approach to charging for intermediate care provided in care homes.

Partnerships reported approaches that ranged from ''Charging consistent with normal terms for care home provision'' to ''Stays over 2 weeks will attract a charge'' and ''No charge applies''.

Table 2 lists the partnerships which are currently providing 'step up / step down' models in care homes or housing with care settings.

Council Care Homes	Aberdeen, Highland, Midlothian, Perth & Kinross, Glasgow City, Borders, Shetland, Renfrewshire, North Lanarkshire, West Lothian, Stirling, Clackmannanshire and Falkirk
Independent Care Homes	Aberdeen, Angus, Dumfries & Galloway, Perth & Kinross, Dundee, Moray, Glasgow City, Aberdeenshire, East Ayrshire, North Ayrshire, South Ayrshire
Sheltered / Very Sheltered Housing	Aberdeen, Renfrewshire, Edinburgh, Stirling, Clackmannanshire and Falkirk West Dunbartonshire, Argyll and Bute

– agree principles for local 'step up / step down' Intermediate Care and involve housing, independent sector and community hospitals

- establish action learning discussions for partnerships testing and evaluating the impact of these models

- SG / COSLA to agree a national position on charging for step up / step down models of Intermediate Care

Raising Awareness of Intermediate Care

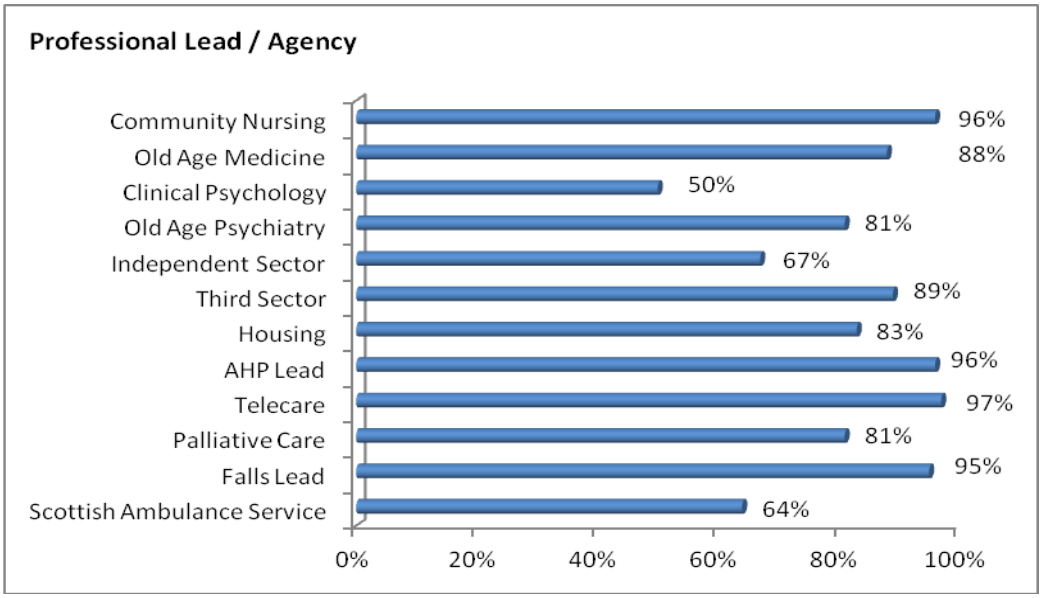
Effective Intermediate Care requires excellent relationships across professional disciplines and agencies. It also needs well signposted pathways that are easily accessed by referring practitioners from primary care, hospital, Out of Hours and emergency services.

Primary Care teams

Anticipatory Care Planning (ACP) and Polypharmacy reviews, included in the GP contract from April 2013, encourage GPs and pharmacists to help people to 'think ahead' and to talk about their preferred support and care if they or their carer become unwell in the future. This new development for Primary Care teams and Pharmacists is an excellent opportunity to discuss local Intermediate Care alternative pathways.

- raise awareness of intermediate care though ACP and polypharmacy work

Fig 3 lists other professionals or agencies that have a role in Intermediate Care



Third Sector

89% of partnerships report involving their Third Sector leads. Support is delivered by local community groups or through service level agreements with British Red Cross, Royal Voluntary Service, Marie Curie and Macmillan services. This support is an example of the community networks, befriending and buddy services being developed through the Change Fund to help older people maintain their wellbeing and independence.

Examples of practical Third Sector support relevant for Intermediate Care are:

- Follow up visits on return home from A&E
- Respite for Carers and sitting Services
- Transport from and to hospital or step-up / step-down beds
- Collection, delivery and return of medicines and equipment
- Reaching adults in remote areas

– connect local Third Sector support with Intermediate Care services

Mental Health Services

The confidence, resilience, mental wellbeing and cognitive ability of the individual and their carer will influence decisions around risk thresholds and suitability for Intermediate Care and support at home. However only 50% of partnerships involve clinical psychology support and only 81% involve old age psychiatry services in their local developments.

- engage with mental health teams and explore shared opportunities from post diagnostic support for people affected by dementia

Unscheduled Care Services

The Scottish Ambulance Service (SAS) responds to around 200,000 incidents involving people aged 65 years and older and conveys to hospital, typically, 80% of these individuals. **'Falls'** are the most frequent single "diagnosis" in this cohort, followed by '**sick older person'.** Both presentations often herald a non-specific deterioration in an older person who has multiple conditions and requires comprehensive assessment. However this is increasingly available by specialist teams in the community or through rapid access to Day Hospital. Yet one third of partnerships are not yet involving SAS in their Intermediate Care work. That means there is a risk that current and new alternative pathways will be bypassed by emergency services responding to a crisis.

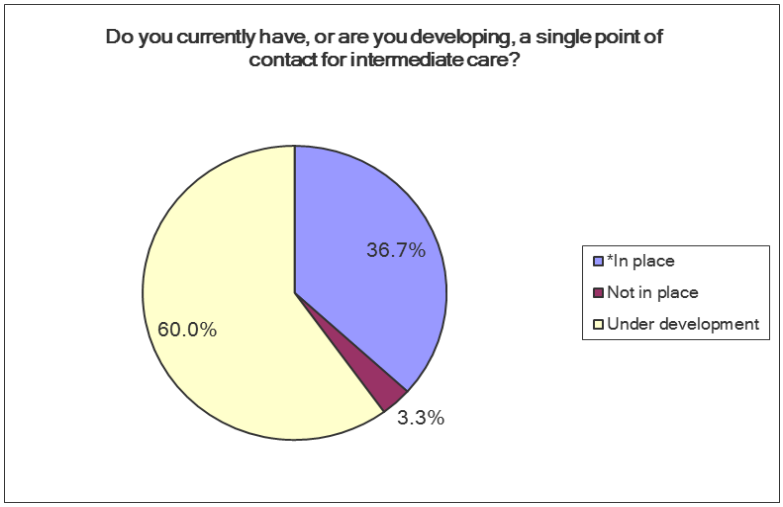
– engage with Unscheduled Care leads, SAS and Out of Hours services so that Intermediate Care is embedded within new emergency pathways

Developing a single point of contact

Most partnerships are developing either a single portal or a 'one phone call' system that streamlines access and improves the navigation and coordination of services provided by different teams and agencies (Fig4).

''there is a desire to integrate working with existing teams and services rather than setting up new teams'' Edinburgh Partnership

Fig 4



Surveys of older people admitted to acute hospitals in Lanarkshire and Glasgow identified that up to 30% of these older emergency admissions may have had a different pathway. The referring practitioner and decision maker often had insufficient knowledge or were unable to directly access appropriate alternative assessment and support.

Referring disciplines need prompt easy access to the most appropriate interventions and services, ideally through a single call.

This may require a central triage system to identify the best immediate response and pathway for the individual, based on the urgency and nature of their needs and intelligence about the local services available.

Examples of work to simplify and streamline access includes:

Grampian already has an Integrated Out of Hours service, based in the Emergency Care Centre, and plans to develop local Single Point of Contact centres for community services and to align these with their GP clusters.

In **Argyll & Bute** local services are co-ordinated via Extended Community Care Teams.

In **Scottish Borders** the community based Short Term Assessment Reablement Team (START) is a single team that provides short term assessment and facilitates hospital discharge

Edinburgh's COMPASS service has developed rapid specialist advice and day hospital assessment along with streamlined access to the local Intermediate Care services in the south of the City

Ayrshire partnerships are creating local hubs to align their community wards, Intermediate care and enablement services and access to rehab beds in care homes.

Dumfries & Galloway have launched a Community Hub to coordinate integrated services within a locality.

Fife has a single point of contact for their Intermediate Care services in three geographical patches

Renfrewshire referrals to Intermediate Care are channelled through ASeRT (Adult Services Response Team).

South Lanarkshire's Integrated Community Support Team operates a single contact for the locality with excellent links to out of hours services and the discharge hub in the local hospital

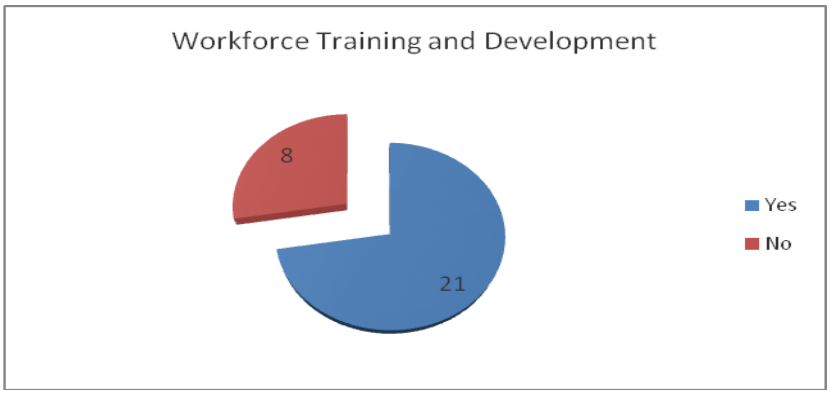
- map and, where appropriate, join up local Intermediate Care services to simplify access

- establish a 'single point of contact' and pathway for local Intermediate Care

Developing the Workforce

Although Intermediate Care requires excellent relationships and clarity of roles and responsibilities across professional disciplines and agencies, only two thirds of the 29 partnerships that responded to this question reported an integrated approach to workforce training and development for Intermediate Care (Fig 5).

Fig 5



As Intermediate Care services are often covered out of hours by other health and care staff, there are implications for training and workforce development beyond those directly delivering intermediate care. Many partnerships are identifying training needs via staff PDPs and KSF. There is a range of in-house training but little national coordination of this activity.

Examples of local activity include:

Argyll and Bute partnership has mapped the workforce across all 4 sectors and identified their prioritised learning and development needs. Training is already underway.

Dumfries & Galloway partnership has developed nationally accredited training in re-ablement that is already delivered on a multi-agency basis.

Dundee partnership has a care home liaison team that supports skill development and provides on-site training for staff within care homes, including their Intermediate Care Unit. The partnership also provides multi-agency training on enablement.

Moray has a joint workforce development plan and co-ordinator.

Fife partnership provides in-house training for Intermediate Care Teams. Nurses involved in Hospital at Home completed additional training through the University of Dundee to develop appropriate skills.

Scottish Borders partnership AHPs provide re-ablement training to support staff within the Intermediate Care Units. There is a broader re-ablement training programme and competency framework to ensure a consistent approach across all providers.

Midlothian has a regular multi-agency Intermediate care meeting for core staff and for local doctors, AHPs and community service managers to keep all abreast of developments, challenges and success

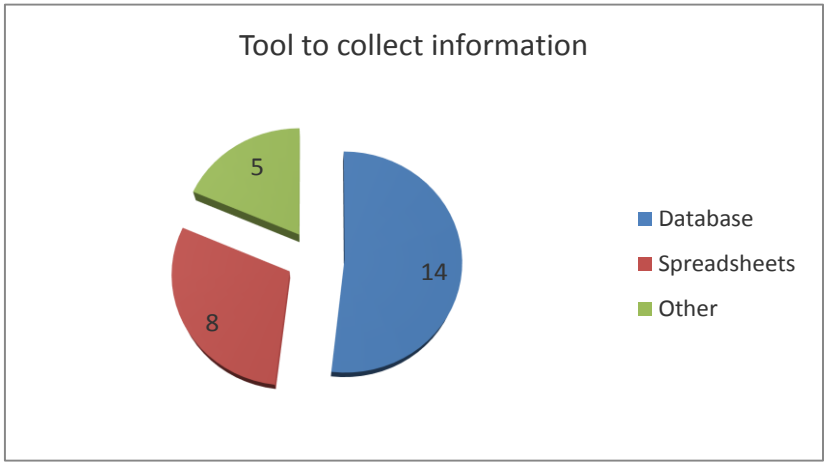
– identify the learning needs and secure local and national support for the required integrated workforce development across sectors

Information

There is currently no agreed dataset to record and report on Intermediate Care activity and outcomes. The challenge around data capture is compounded by the range of settings in which Intermediate Care is provided and the varying acuity of care delivered - from Hospital at Home to supported discharge and re-ablement. Each of these components and settings will have specific requirements for data capture.

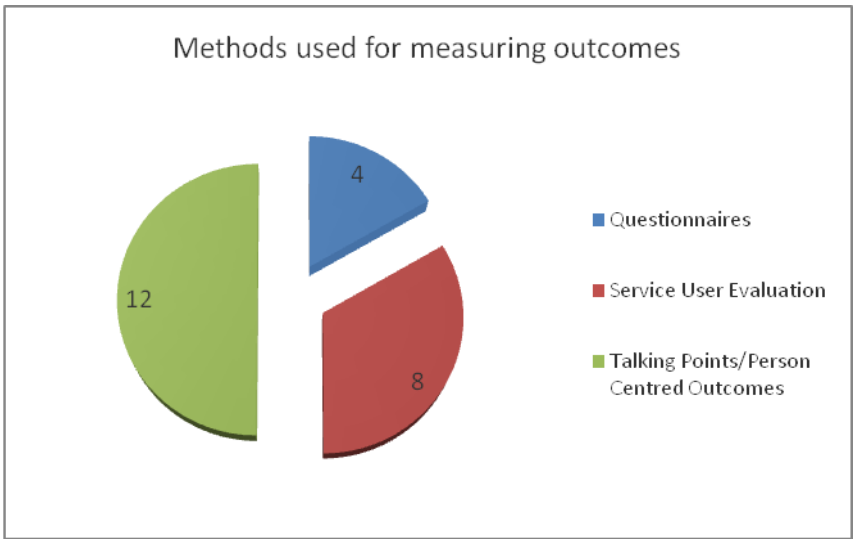
Partnerships are currently using various stand-alone and bespoke databases to produce reports (Fig 6). They are adapting local systems such as Midis, SWIFT, TRAK, Care First and Gmed.

Fig 6



Outcomes are most commonly recorded through the adoption of person centred outcomes within assessment and care planning or through specific service user questionnaires or evaluation surveys (Fig 7). The remaining partnerships reported a mixed approach to capturing staff feedback, patient and client stories and changes in the Indicator of Relative Need (IoRN) scores.

Fig 7



– develop a common dataset and reporting for Intermediate Care with an initial focus on Hospital at Home and 'step up / stepdown' activity in care homes and community hospitals.

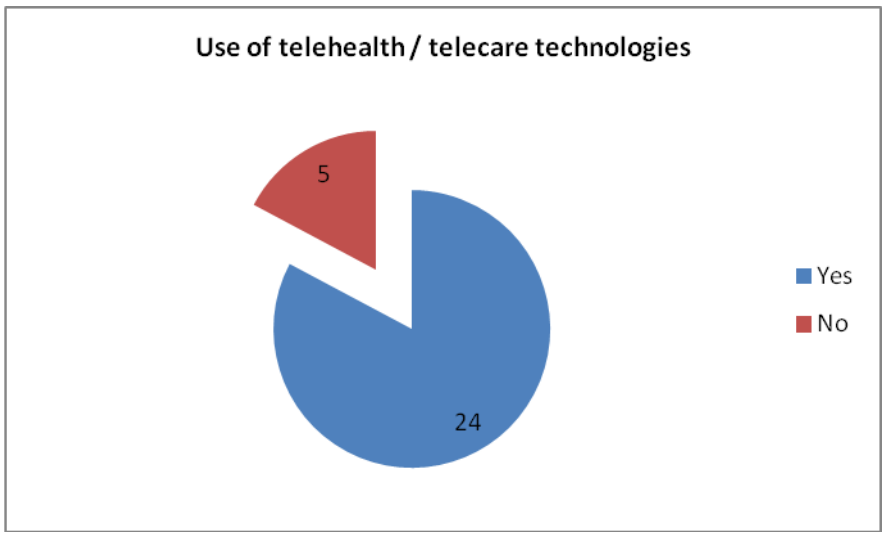
Telehealth and Telecare

Of the 29 partnerships that completed the question around telehealth or telecare, most reported using telecare within their Intermediate Care pathways but few have yet adopted technology to support remote monitoring or remote consultation (Fig 8).

However most partnerships expressed an interest in testing these technologies.

There is a specific interest in the use of technology to improve the safety and effectiveness of medication administration for people receiving Intermediate Care as they often have frequent changes in their multiple prescribed drugs and prescribing may be shared between primary and secondary care teams.

Fig 8



Examples of responses

Aberdeen - telecare is well used and there is good access to an extensive network for telehealth via NHS Grampian community hospitals and services

North Lanarkshire –people receiving Intermediate care in 2 council care homes are supported to use telecare applications where appropriate, with the expectation of transferring their newly learned skills on return home.

Dundee is in the process of kitting out an assisted technology flat and may use this as part of their Intermediate Care assessment service.

Glasgow City partnership is keen to use telehealth in their pathways for people with Chronic Obstructive Pulmonary Disease (COPD

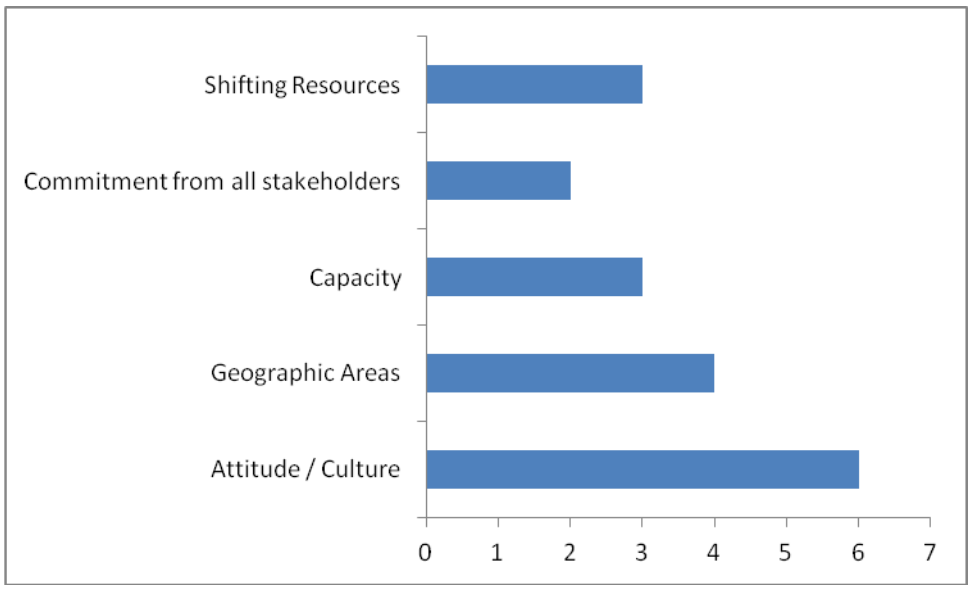
East Lothian Emergency Care Service responds 24/7 to telecare alerts and supports clients in crisis to prevent admissions to hospital and care homes.

– work with the Scottish Centre for Telehealth and Telecare to test the use of technology to optimise skill mix, enable remote monitoring and consultation and improve the safety and efficacy of medication administration

Barriers to Spread

Partnerships were invited to identify perceived barriers to developing intermediate care. The most common theme from free text responses was shifting attitudes and culture (Fig 9).

Fig 9



Points that were raised included:

- Lack of understanding of the services that local partners currently provide
- Community and elected member / political opposition to new models
- Getting staff to think differently about safety thresholds
- Workforce development and clinical governance issues
- Different strands of service currently managed in different organisations
- Impact on Independent sector of fewer long term placements
- Limited or slow access to pharmacy support in the community
- Lack of clarity on the role of NHS 24
- GP and consultant engagement
- Shifting resources from hospital settings

''Systems and processes are important. But we also need a greater focus on people and cultures - especially around issues of tolerance and risk.''

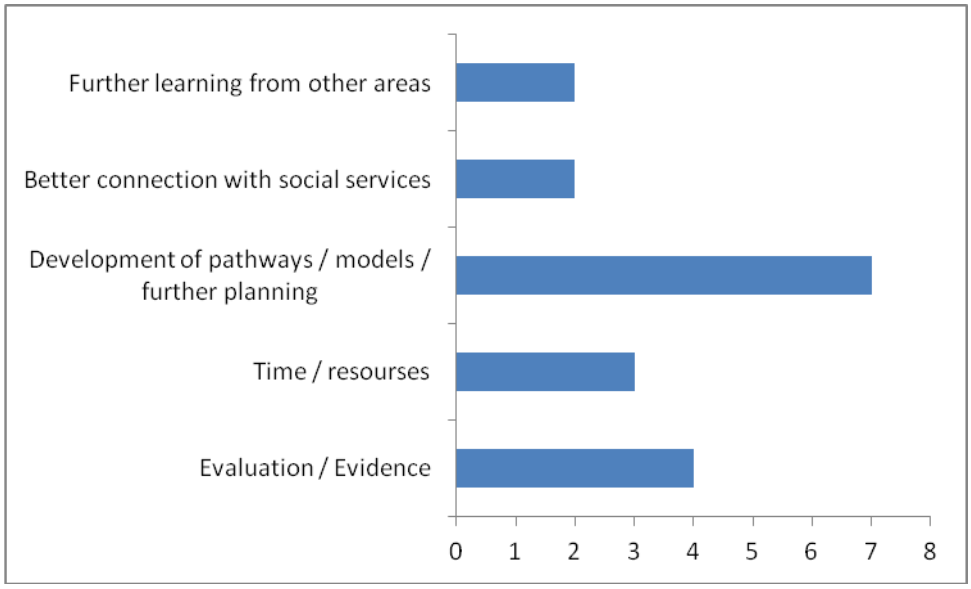
''This is a massive redesign with no or diminishing resources.''

''Lots of change, a bit over whelming.''

Scaling Up Intermediate Care

Partnerships were invited to suggest what would help them to scale up intermediate care. The most common themes from free text responses were support to develop pathways, to share learning and demonstrate the impact of services (Fig 10). Capacity, time and resources were also identified as factors that would enable spread and scaling up.

Fig 10



Specific supports and enablers listed included:

- Forums for sharing 'good practice', protocols/documentation and training.
- Evidence from evaluation of pilots, including views from service users
- Combining services to make better use of resources
- Long term whole systems planning and integrated health and social care budgets
- Release of resources from bed based models
- Better and more housing options
- Increased involvement of Third sector
- Professional support for community alarm /ambulance staff to avoid admissions
- Implement National Delivery Plan for AHPs and a shift towards community provision
- Substantive GP Input to Care Homes and Advanced Nurse Practitioners out of hours
- Improvements in single point of contact and shared IT systems

‘’This is not a quick fix and needs an investment in time.’’

‘’Time out to pull all the strands together ! ‘’

Supporting Improvement

JITs Intermediate Care Group is working with national partners to take forward the enabling actions identified by partnerships. Current and planned actions include:

- Including a focus on Intermediate care within the Improvement Programme on Joint Strategic Commissioning and Integrated Resourcing
- Holding a workshop session on Sep 4th for Reshaping Care leads, HEAT leads and Community Hospital executive leads to highlight the contribution of Intermediate Care to reducing Delayed Discharge and rates for 75+ emergency bed days
- Contributing to a development session for Unscheduled Care leads to highlight the contribution of Intermediate Care to Local Unscheduled Care Plans
- Participating in the Task and Finish group on Prof – prof advice for ambulance staff
- Supporting a Task and Finish Group with ISD to develop a common dataset and approach to demonstrating impact of Hospital at Home and step up / step down beds
- Supporting a Task and Finish group to identify workforce learning and development needs and support for staff currently delivering new models of Intermediate Care
- Working with SCTT and ehealth to identify and test opportunities from technology
- Facilitating a learning exchange on Step Up / Step Down models in care homes
- Holding workshops on re-ablement for Third and independent sector providers
- Co-hosting 3 improvement and innovation workshops with leads for primary care, pharmacy, community nursing, old age medicine and AHP services: Oct 22nd (Dundee); Nov 1st (Heriot Watt) and Nov 7th (Kilmarnock). Invites will be circulated via partnership leads for Reshaping Care and Intermediate Care.

Sharing Good Practice

The final section of the Survey invited partnerships to signpost examples of good practice. JIT is now collecting case studies and supporting documents for these examples using the one page template in **Appendix 2.**

We would be delighted to receive completed templates and any supporting materials that you are willing to share. Please send these to Marie Curran, JIT Improvement lead for Intermediate Care, by emailing Marie at tonmar@sky.com

The Intermediate Care learning resources will be shared through a new community of practice portal that is being established for Community Hospitals and Intermediate Care.

This Community Hospitals and Intermediate Care Network website is currently being developed by NHS Education for Scotland. This will also link to the JIT Website.

JIT has recently updated our library of digital stories on Intermediate Care. These will be uploaded to the community of practice in the coming weeks. We would welcome a copy of any DVD you may have recorded on aspects of your local Intermediate Care services.

Appendix 1

Intermediate Care Leads and Contact Details

Partnership	Name	Job Title	Contact Details
Aberdeen	Sandy Reid	Programme Development Manager	SandyReid@aberdeencity.gov.uk 01224 522245
Aberdeenshire	Rieta Vilar	Programme Manager (Aberdeenshire CHP)	rieta.vilar@nhs.net 01467 – 672787
Angus	Susan MacLean	Service Manager	MacLeanSE@angus.gov.uk] 01307 465143
Argyll and Bute	Pat Tyrrell	Lead Nurse	p.tyrrell@nhs.net 01546605645
Clackmannanshire	Maureen Dryden / Linda Melville	Service Manager	mdryden@clacks.gov.uk 07972862533
Comhairle nan Eilean Siar and NHS Western Isles	Paul Dundas	Head of Service, Community Resources	paul.dundas@cne-siar.gov.uk 0845 6007090
Dumfries & Galloway	Geoff Mark	Commissioning Manager Older Adults	Geoff.Mark@dumgal.gov.uk 01387 260955
Dundee	Diane McCulloch	Head of Service	diane.mcculloch@dundeecity.gov.uk 01382 438306
East Ayrshire	Stuart Gaw	Manager Intermediate Care & Enablement Service	stuart.gaw@aapct.scot.nhs.uk 07810181435
East Dunbartonshire	Ian Nicol	Older People's Transformational Programme Manager	ian.nicol@ggc.scot.nhs.uk 0141 201 3532

East Lothian	Gillian Neil	Area Manager	gneil@eastlothian.gov.uk 01875 824 078
East Renfrewshire	Zaid Tariq	Reshaping Care for Older People - Planning and Development Officer	Zaid.Tariq@eastrenfrewshire.gov.uk 0141 577 3558
Edinburgh	Caroline Clark	Planning and Commissioning Officer - Older People	c.clark@edinburgh.gov.uk 0131 469 3220
Falkirk	Shiona Hogg	AHP Manager for Rehabilitation	shiona.hogg@nhs.net 01324 673737
Fife	Val Hatch	Reshaping Care Lead	val.hatch@nhs.net 01383565455
Glasgow City	Rhoda Macleod / Christine Ashcroft	Adults Services Managers	christine.ashcroft@ggc.scot.nhs.uk 07789396330
Highland	Jan Baird	Director of Adult Care	jan.baird@nhs.net 01463 706757
Inverclyde	Emma Cummings	Project Manager RCOP	emma.cummings@ggc.scot.nhs.uk 01475 715395
Midlothian	Anthea Fraser	Resource manager - Older people	anthea.fraser@hotmail.co.uk 0131 271 3670
Moray	Sandra Gracie	Strategy Development Officer, Change fund lead	sandra.gracie@nhs.net 01343 567184
North Ayrshire	Stuart Gaw	Manager Intermediate Care & Enablement Service	stuart.gaw@aapct.scot.nhs.uk 07810181435
North Lanarkshire	Joe McElholm	Manager Older Adults, North Lanarkshire Housing and Social Work Service	Mcelholmj@northlan.gov.uk 01698332031
Orkney	Caroline Sinclair	Head of Health & Community Care	caroline.sinclair@orkney.gsx.gov.uk 01856 873535 Ext 2616

Perth & Kinross	Sue Muir	Service Manager	sue.muir@nhs.net 01738 473119
Renfrewshire	Marian A McGhee	RES Manager	marian.mcghee@ggc.scot.nhs.uk 0141 618 7638
Scottish Borders	Angie Lloyd-Jones	Strategic Lead OT & Reablement	alloyd-jones@scotborders.gov.uk 01835825080
Shetland	Sally Shaw	Director of Community Care	sally.shaw@shetland.gov.uk 01595 744310
Stirling	Maureen Dryden or Linda Melville	Service Manager	drydenm@stirling.gov.uk lmelville@clacks.gov.uk 07972862533 (MD) 07966151594 (LM)
South Ayrshire	Stuart Gaw	Manager Intermediate Care & Enablement Service	stuart.gaw@aapct.scot.nhs.uk 07810181435
South Lanarkshire	Helen Edment	Implementation Manager	Helen.Edment@lanarkshire.scot.nhs.uk 01698 858137
West Dunbartonshire CHCP	C McNeill	- Head of Community Health and Care Services	chris.mcneill@ggc.scot.nhs.uk 01389737315
West Lothian	Carol Bebbington	Primary Care Manager	carol.bebbington@nhslothian.scot.nhs.uk 01506 281017

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Appendix 2

Intermediate Care Case Study Template

This should be no more than one page long, signposting readers to further information and contacts.

Partnership:

Case Study Name:

Summary (up to 100 words).

Describe the target group, setting, approach, disciplines, agencies, development tools

What were the outcomes - benefits or otherwise? How did you measure these?

Would you do anything differently?

Contact or link(s) to further information on pathway / protocol / evaluation / data if available

In order to help us to share and signpost others to this good practice, please tick each box that your case study relates to:

Rehabilitation and re-ablement	
Rapid access to day hospital	
Multi-agency rapid response at home	
SAS see and treat	
Falls and fracture prevention	
Early supported discharge	
Intermediate care in care home	
Intermediate care in sheltered / extra care housing	
Hospital at Home	
Integrated Community Team	
Single point of access	
Evaluation	
Workforce development	
Information and data	
Technology	

Please send completed template and any supporting documents you can share to

Marie Curran
JIT Improvement lead for Intermediate Care

tonmar@sky.com