

Maximising Recovery, Promoting Independence:

An Intermediate Care Framework for Scotland



“Intermediate Care provides a bridge between locations, sectors and different states of health and wellbeing”

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Foreword

Scotland is facing some radical changes in the way health and social care is delivered. Our plans for the integration of adult health and social care will ultimately improve the outcomes for our most vulnerable citizens by improving the quality, efficiency and financial sustainability of health and social care services.



To achieve these ambitions we must deliver person-centred community based services that will help people to live healthy, independent lives in the way they want, where they want, and when they want.

Intermediate Care and rehabilitative services have a vital role to play in delivering these objectives. In particular, Intermediate Care can help shift the balance of care away from hospital and can reduce the need for alternative, longer-term care services, such as home care, or permanent admission to a care home.

The Third and Independent sectors have a key role to play in the delivery of these interventions. WRVS, for example provide vital services both within our hospitals and the wider community. Everyone will be aware of the WRVS shops within our hospitals, but they do much more than this, such as their home from hospital scheme and befriending services. Third sector organisations can help provide that vital link between the older person and the outside world at a time when they are still recovering from an accident or illness and may feel vulnerable and isolated.

Much is said about the demographic challenges we are facing in relation to older people, and we must be mindful of this as we move forward. However, we should also remember that older people continue to contribute to our society in a variety of ways. Indeed, many third sector services survive due to the dedication and hard work of volunteers, many of whom are older people themselves.

We must nurture and encourage these resources to grow and develop further. By taking a co-production approach to commissioning adult health and social care services we will ensure that a rich and varied community of services can be developed, focused on the best outcomes for the people of Scotland. Intermediate Care services will form a vital part of community services.

I encourage health and social care partnerships to consider the details of this Framework, which I am pleased to say also has the endorsement of the COSLA Health and Wellbeing Executive Group, with a view to further developing Intermediate Care within local areas.

A handwritten signature in black ink, appearing to read 'Michael Matheson'.

Michael Matheson, MSP
Minister for Public Health

1. Introduction

To be better informed about my options and choices, and be actively involved in decisions about my own care

I don't want to spend unnecessary time in hospital. We need better community services to avoid being unnecessarily delayed

Better support for unpaid carers

More specialist services for people with dementia

To stay in my own home for as long as possible

The **Reshaping care for Older People programme's** public engagements collected clear messages about what people want for their future care.

Enabling people to live independent lives, with meaning and purpose, within their own community, is a fundamental principle of social justice and an important hallmark of a caring and compassionate society.

Demographic changes, alongside a decade of difficult finances, means this is one of the 3 biggest challenges facing Scotland – alongside economic recovery and climate change. The extent of the challenge we face in caring for older people, along with our approach to meeting this challenge, have been set out in [**Reshaping Care: a programme for change 2011-2021**](#)ⁱ.

Older people and people with long term conditions are major users of health and social care support services in both the statutory and third sectors. Although the full social and economic costs of long term conditions in Scotland is not known, it is estimated that costs for mental health problems alone are around £8.6 billion, or 9% of GDPⁱⁱ.

Enabling and Intermediate Care (IC) are a core element of our strategy to re-shape our health, care and support services for older people and those with long term conditions.

IC supports the key objectives to enable independence and avoid unnecessary admission, or stay, in hospital or a permanent admission to a care home by providing a 'bridge' or transition through services at key points of crisis in people's lives.

There is growing recognition of the important contribution made by IC not only in Scotland but in the rest of the UK and internationally. In Scotland, the Joint Improvement Team (www.jitscotland.org.uk) provided funding for five Intermediate Care 'demonstrators' in 2009/10 to increase the pace of development and to develop practical tools and solutions which could be shared across Scotland.

2. Purpose of the Framework

The purpose of this Framework is to:

- Raise awareness of Intermediate Care, and its link with wider, long term, enabling and rehabilitative services.
- Encourage and guide the development of Intermediate Care as part of a range of enabling and preventative services.
- Set out links with [Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult rehabilitation in Scotland](#)ⁱⁱⁱ, the new Allied Health Professionals Delivery Plan, and the [Community Hospital Strategy](#)^{iv}

The document provides a Framework for local health and social care partnerships to review and further develop Intermediate Care within their area. It identifies the common and key components that should make up these services, however they may be configured.

We recognise that Intermediate Care can describe a wide range of services, so this Framework does not describe a specific model, but provides an overview of the issues to be considered when developing or reviewing local enabling services.

The Framework also provides [evidence](#) of the benefits of developing Intermediate Care as part of a range of enabling services, along with practical examples of successful services currently in operation across the country.

Intermediate Care encompasses a range of functions which focus on [prevention](#), [rehabilitation](#), [reablement](#) and [recovery](#), depending on the needs of the individual.

Specifically, the Framework includes:

- (a) a working [definition](#) of Intermediate Care
- (b) the principles and outcomes which should underpin Intermediate Care
- (c) the reasons for the further development of Intermediate Care in Scotland, looking at the [policy context](#), and the evidence of its impact and effectiveness
- (d) the [components](#) of an effective and coherent Intermediate Care system, drawing on practice examples from across Scotland.

The lead for the development of IC will lie with local health and social care partnerships; but this approach is about more than just health and social care services. This Framework is also relevant to housing, and the third and independent sector providers as equal partners.

3. What is Intermediate Care?

“The function of intermediate care – inherent in its name – is to **integrate, link** and provide a **transition** (bridge) **between locations** (home/hospital and vice versa); **between different sectors** (acute/primary/social care/housing); and **between different states** (illness and recovery, or management of acquired or chronic disability).”

An Evaluation of Intermediate Care for Older People, Institute of Health Sciences and Public Health Research, University of Leeds, 2005

Rehabilitation, reablement and Intermediate Care (IC) are all terms that have currency in a variety of health and social care settings. However, they all stem from a desire to enable individuals to live independent lives with meaning and purpose, to empower individuals to be self determined, and to avoid dependency on health and social care.

Intermediate Care is an ‘umbrella’ term describing an approach involving a collection of services working to common, shared objectives and principles. It provides a set of ‘bridges’ at key points of transition in a person’s life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence; helping them achieve their personal outcomes.

By its nature in acting as a bridge between locations, sectors and personal circumstances, there must be close connections with mainstream services – whether the acute sector or community based services.

Intermediate Care should be brought in at times of “crisis” to complement existing care services (where these are in place), providing a person centred, outcomes focused package of care. It can also form part of a range of planned interventions, this is particularly important for those with long term conditions. Wherever possible this will be provided in the person’s own home, but a range of services are likely to be needed, including care homes and community hospitals. Good practice would suggest that part of the suite of services provided in local areas should be available on a 24/7 basis, with a fast, easy, single point of access to assessment.

The diagram on the following page illustrates how Intermediate Care can be delivered to ensure the best quality care is provided at a point of crisis to avoid an acute admission, or to assist in returning that person to the community.

Level of acute need



Individual becomes unwell.
Primary care; District Nurse;
Social Work; Home Care; NHS24;
Ambulance practitioner; A&E
attendance.

Contact Single Point of Access

Assessment

Intervention as required:

- Nursing
- Therapy
- Support Worker
- Telecare

Timely diagnosis by GP

Specialist input by:

- Geriatrician
- Community diagnostics
- Rapid Response Team



If too unwell to be cared for at
home, step up to a care home,
community hospital or other
residential setting.

History / Examination /
Diagnostics.

GP, Nurse practitioner or
Consultant review within 24 hours.

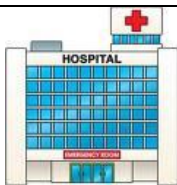
MDT input with principle of care
delivery at home when
appropriate (as it may be in a care
home).



If too unwell to be cared for in a
community facility, admit to acute
hospital for comprehensive
assessment.

Transfer to community facility or
home when medically stable and
fit for transfer.

Level of need during recovery



Timely comprehensive
multidisciplinary and multi-agency
assessment :

Rehabilitative need identified.

Referral to Intermediate Care
Single Point of Access.

Individual is medically stable and fit
for transfer.

Individual transferred to the
appropriate setting:

- Own home
- Community based facility (such
as a care home or community
hospital)



If the individual requires more care
than can be delivered at home,
step down from acute hospital to a
care home, community hospital or
other residential setting.

Regular MDT and GP / Nurse /
Consultant review with principle of
care at home to continue
rehabilitation when appropriate



Majority of users of Intermediate
Care to receive their episode of
care at home.

MDT driven re-ablement to
optimise recovery and promote
independence.

4. Why do we need Intermediate Care?

A well configured, integrated health and social care system which includes a range of Intermediate Care options can contribute significantly to the reshaping care agenda by:

- **Preventing** unnecessary acute hospital admission or premature admission to long-term care;
- **Supporting** timely discharge from hospital;
- **Promoting** faster recovery from illness, and
- **Supporting** anticipatory care planning and the self management of long-term conditions.

The need for change is clear - the **demographic changes** facing Scotland are well documented:

- over 65 population projected to increase by 22% by 2020, and by 63% by 2035;
- The over 75 population predicted to increase by 23% and 82% over the same period^v;
- over 85 population will increase by 39% by 2020 and 147% by 2035.

We currently spend approximately £5.1 billion¹ of public funding each year on health and social care for those over 65 years across Scotland. Well over half (60%) of this is spent on care in hospitals and care homes (and almost one-third on emergency admissions to hospital).^{vi} Overall, emergency admissions by older people absorb £1.4 billion each year and are expected to grow unless we radically change our approach to addressing peoples needs in the community.

¹ Estimated figure for 2009/10

“Our policy goal is to optimise the **independence** and **wellbeing** of older people at home, or in a homely setting. This will involve a substantial shift in focus of care from institutional setting to care at home – because it is **what people want** and provides better value for money.”

Reshaping Care for Older People:
A Programme for Change 2011-2021

This projected growth in the older population will create significant additional demand on health, care and support services. Assuming that demand increases in line with the growth in the older population and that current service models remain the same, we would require an annual increase in investment in health and social care services alone of £1.1 billion by 2016. There will be additional demands on other services.

Reshaping our services for older people can change this. We have already made some progress in this area, but we need to do more. Intermediate Care has a key role to play in meeting the health and social care needs of people in Scotland.

Preventing unnecessary acute hospital admission or premature admission to long-term care

An important concern for older people is the increasing likelihood of unplanned or emergency hospital admission as they develop more long term conditions and complex needs. The probability that someone will be admitted to hospital increases with age ([Chart 1](#)) as does the average time spent in hospital after admission ([Chart 2](#)).

Many admissions are absolutely necessary. Some however can be avoided - if we take the right anticipatory action and if we ensure that effective alternatives are available in the community. A key outcome of reshaping care will be reducing the number of bed days used as result of emergency admissions to hospital by older people.

A new NHS [HEAT target](#) introduced from April 2012 is to reduce 75+ emergency bed day rates by at least 12% nationally between 2009/10 and 2014/15.

To avoid unnecessary admission to hospital alternative community services need to be in place to effectively respond to those in crisis. Providing a range of integrated intermediate interventions within community services will ensure timely support is available to those who need it, where they need it. Intermediate Care is not just a health, or social care agenda. There is a role for all – health, social care, housing, the third and independent sectors – alongside families, carers, neighbours and the wider community.

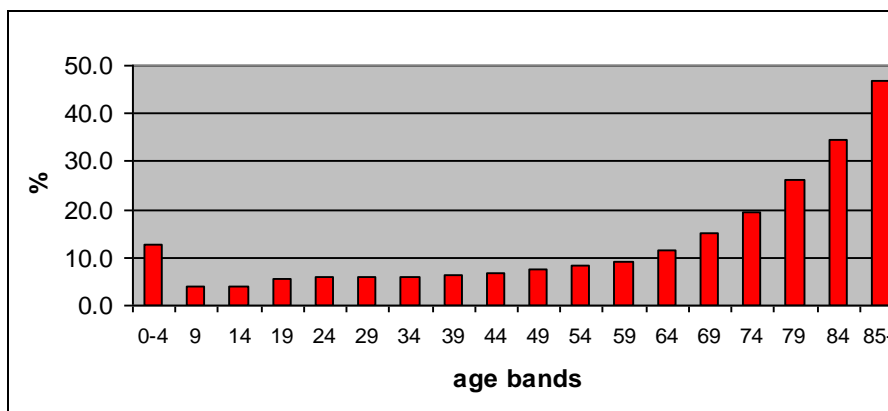


Chart 1: Emergency admissions as a percentage of population in age band

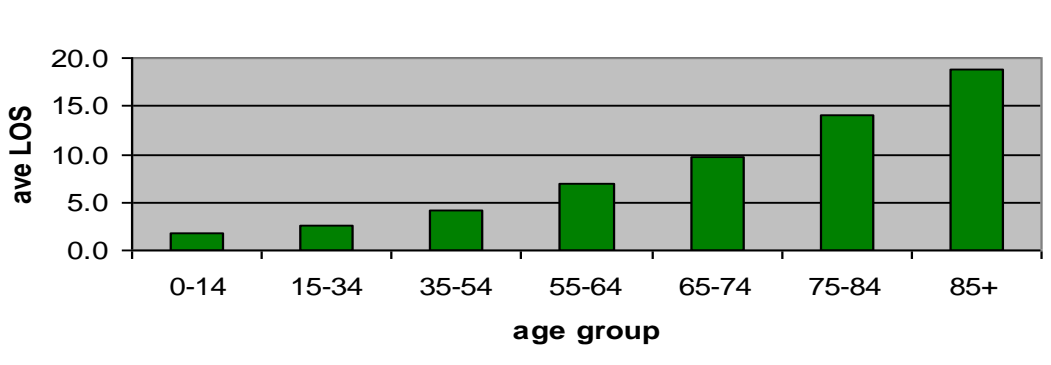


Chart 2: Average length of stay per emergency admission by age

Supporting timely discharge from hospital

Unnecessary delays in discharge from hospital are not only costly to the NHS but are detrimental to the health and wellbeing of the individual.

Unnecessary delays can lead to decreased independence and life skills, lack of confidence and a risk of further illness. All of this can lead to an increased risk of premature admission to a care home, instead of a return home.

The risk of becoming delayed in hospital increases when a patient is admitted as an emergency, and the longer the delay the greater the chance of dependency and a reduced chance of a return home. Therefore both the emergency admission and its outcome may be expensive – in financial and human terms. In contrast, greater support upstream might have helped to prevent an avoidable admission, at lower cost.

Our evidence demonstrates the need for public services to become **outcome-focussed, integrated and collaborative**. They must become transparent, **community-driven** and designed around users' needs. They should **focus on prevention and early intervention**.

Commission on the Future Delivery of Public Services

There has been much progress in tackling delayed discharges. In October 2001 there were more than 2,000 patients delayed longer than 6 weeks.

New Delayed Discharge Target

Partnerships will reduce to zero the number of delayed discharges:

- over **28 days by April 2013**, and
- **over 14 days by April 2015**

A target to reduce this to zero by April 2008 was achieved and the numbers delayed over 6 weeks generally remain below 100.

However, delayed discharges still account for nearly a quarter of a million bed days lost.

An expert group, jointly established between the Scottish Government, NHSScotland and COSLA, reported at the end of September 2011^{vii}.

The group recognised the achievement over the last few years but felt that, from an outcomes perspective, a six-week delay in hospital discharge is too long in nearly all cases. The group suggested that major cultural and behavioural change was needed to move to a position where discharges routinely take place in days and not weeks and that people are, wherever possible, discharged home or to where they were admitted from.

Promoting faster recovery from illness

It is clear that prolonged hospital stays are generally not good for a person's general wellbeing, especially their sense of control and independence.

To ensure that their potential for recovery is maximised, an individual should have the opportunity to recover at home or within a community setting supported, where required, by an appropriate package of Intermediate Care.

This recovery time could avoid premature admission to a care home - currently, too many older people are discharged directly from hospital to a care home at a time when their confidence is low following an acute illness.

The development of Intermediate Care, such as Rapid Response Teams; community assessment and rehab teams, or hospital at home schemes, can help avoid admission to the acute sector, promote faster recovery from illness, and reduce delays to discharge from hospital.

Supporting anticipatory care planning and self management of long-term conditions

"Introduce a systematic and integrated multi-agency approach across CHPs to provide better, local and faster access to services for people with long term conditions who require proactive and co-ordinated support."

Improving Health & Wellbeing Of People With Long Term Conditions In Scotland: A National Action Plan

Around 2 million^{viii} people in Scotland have at least one long term condition, and one in four adults report some form of long term illness, health problem or disability. Long term conditions become more common with age. By the age of 75, nearly two-thirds of people will have developed a long term condition. 27% of people aged 75-84 have two or more such conditions.

The human costs of long term conditions and the economic consequences for health and social care are profound.

- Sixty per cent of all deaths are attributable to long term conditions and they account for 80% of all GP consultations^{ix}.
- People with long term conditions are twice as likely to be admitted to hospital, will stay in hospital disproportionately longer and account for over 60% of hospital bed days used.
- Most people who need long term residential care have complex needs from multiple long term conditions.^x

"People with dementia want services which **maximise capacity for independence** and which connect or reconnect people with dementia with the people and activities important to them."

Scotland's National Dementia Strategy

Approximately 71,000 people in Scotland have dementia, around 2,300 of whom are under 65. Alzheimer Scotland estimates that the cost associated with Dementia are £1.7 billion per annum. Of that cost around £600 or £700 million is the cost of care and treatment services provided by the NHS and local government. The remainder is the contribution made by carers^{xi}. There are 657,000^{xii} carers in Scotland saving the Health and Social Care system an estimated £10.3 billion.

Most people with dementia (over 60%) live at home, with carer support from family members (usually a partner or daughter), often supported by a range of community and health care services.^{xiii}

- Older people with dementia will have significantly more functional decline, longer lengths of stay, increased risk of admission to a care home and higher mortality rates. It is well known that elderly people with significant physical disease are at greater risk of co-existent psychiatric morbidity^{xiv}.
- People with dementia are many times more likely to be admitted to hospital compared with older people who do not have dementia.

Most people who live with a long term condition manage their own condition or do so with help from family, unpaid carers or from community and voluntary sector partners. Supported self management encourages people to take decisions and make positive choices about their health, wellbeing and health-related behaviors. It involves a holistic assessment of personal goals. A self management plan is a way of recording these personal goals and the supports people need to achieve them. It is designed to be held and used by the person at home.

A recent study aimed at reducing unplanned hospital admissions highlighted that the use of Anticipatory Care Plans for those at high risk of a hospital admission was found to reduce the number of admissions and occupied bed days^{xv}.

Anticipatory care planning encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis. This approach supports important outcomes:

- Person centred care, dignity, choice and control
- Effective co-ordination and communication between the individual, their family and the health and social care professionals involved
- Planning for the future at a stage when the person can make their preferences known, enabling them to be actively involved in planning their own future.
- Care at home where appropriate, or care which is more local and closer to home.

5. Key components of an effective Intermediate Care system

The following are key components of Intermediate Care:

- **Clear, agreed scope**, focused on ***prevention, rehabilitation, reablement and recovery***; for those at risk of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home.
- **Time limited**, linking and ***complementing existing services***
- **Accessible, flexible and responsive** through a single point of access, 7 days a week, and 24 hours a day
- Based on **holistic assessment** to maximise independence, confidence and ***personal outcomes*** sought by the individual
- **Co-ordinated**, able to draw on ***multi-professional and multi-agency skills*** and resources as required to meet complex needs
- **Managed for improvement**, gathering information on the impact of interventions and using this to inform service improvement.

Clear, agreed scope, focused on prevention, rehabilitation, reablement and recovery

Partnerships should set out clearly the **scope** of the local IC system. This should make it clear the profile of needs and circumstances which IC can assist. This should be developed in collaboration with all stakeholders and reflect the overall purpose of Intermediate Care and the particular needs in the area.

Partnerships also need to understand the range of different needs within their local population. Understanding the needs of the local population will assist commissioners to develop appropriate services, with the right skill mix to meet the range of needs identified.

Intermediate Care is concerned with **prevention, rehabilitation, reablement and recovery**– building on support for self management and anticipatory care by helping to avoid the need for emergency admission to acute hospital (prevention and early intervention); promoting faster recovery and more timely discharge (rehabilitation & recovery); and helping people to re-learn vital life skills (reablement). Intermediate Care brings benefits both to the people using it and to the health and social care system. Its focus should therefore be on those **at risk** (of emergency hospital admission or delayed discharge); and those with

potential to regain confidence and independence.

The use of **Anticipatory Care Plans (ACPs)** supports those with long term conditions to make informed decisions and plan for an expected change in health or social status.

“An Anticipatory Care Plan is a dynamic record that should be developed over time through an evolving conversation, collaborative interactions and shared decision making. It is a summary of discussions between the person, those close to them and the practitioner.”^{xvi}

Where an individual does not have an ACP thought should be given to developing one prior to the completion of their episode of Intermediate Care. Where appropriate, time should also be taken to discuss with the patient and carer how they can look after their health and wellbeing at home. The nature of self management support will vary depending on the individual, but could include general advice on healthy eating and exercise, specific information and advice on, for example, changing a dressing, managing their medicines or foot care, or signposting to local community support.

Key Information Summary

ACPs and other forms of e-records also need to be shared with the full range of care providers, including SAS so that all services can respond appropriately to the needs and wishes of the individual. The **Key Information Summary (KIS)**^{xvii} has been developed as an electronic method of sharing patient information with all clinicians, including SAS.

Developing on the Emergency Care Summary and electronic Palliative Care Summary, the KIS has been designed to support people with long term conditions, mental health problems and individuals requiring special alerts.

In **Chapter 7** we set out some **scenarios** which relate to the wide range of different needs and circumstances of those who could benefit from Intermediate Care.

We encourage local partnerships to think in particular about the needs of:

- A frail older person who **falls at home** or in a care home.
- A **homeless person** with complex medical and social problems .
- A person with a **long term condition** whose condition deteriorates.
- An older person with **dementia**, who develops an acute health problem.
- A person **recovering from a stroke**, whose housing no longer suits their needs.
- Additional pressure on carers following a hospital episode (of the cared for person).

In practice, IC has particular relevance to older people, particularly those aged over 75 and 85, who are at greatest risk of admission to hospital and where there is a related risk of a delay in discharge or admission into a care home. This is often at a key point of transition in their lives, as they acquire a chronic illness or disability, or experience some sort of acute illness, such as a fall or infection.

However, as there is no common understanding about the purpose, scope and needs profile for IC, not all who would benefit are referred on.

Partnerships should set out clearly those who would benefit from Intermediate Care and ensure that this is widely understood, and that all individuals have the opportunity to benefit from Intermediate Care.

The full scope of the local Intermediate Care system is potentially very wide. While it should clearly be the medium term aim to enable it to assist all of those who would benefit, in practical terms it is sensible to start with a more limited scope and expand it over time as systems, processes and staff skills and experience develop.

This more limited scope could be around particular profiles of need, or circumstances; or it could be that it makes sense to start in a particular location. Whichever approach suits the local area, it is important (a) to set the programme for scaling up, and (b) to ensure that this is understood and shared amongst staff and partners.

Time limited, complementing existing services

The purpose of Intermediate Care is to provide **time-limited** interventions at points in a person's life where this will restore or avoid a loss of independence and confidence, or reduce the risk of hospital admission (or a longer stay in hospital).

Experience suggests that Intermediate Care should extend for up to 6-8 weeks. After this period of time, the pace of recovery tends to slow and the person no longer receives the same level of benefit from the intensive interventions associated with Intermediate Care. However the period of time during which Intermediate Care should be provided should reflect the needs of the individual and be shorter, or longer, as appropriate. Intermediate Care is one form of rehabilitation targeted at those who will benefit from short term, intensive, and multi professional interventions: other rehabilitation services may well continue (as may the period of recovery) well beyond this 6-8 week period.

Intermediate Care should be provided, **free of charge**, to people in their own homes where possible: this reflects the clear priorities of older people. Free and effective Intermediate Care has the potential to pay its own way, when commissioned as part of a wider suite of integrated resources.

Intermediate Care in these circumstances is additional, and should be **complementary**, to any existing services that the person receives. It should not displace existing care and support arrangements, but seek to enhance and keep these in place.

This continuity is of particular importance for older people who are confused, and where maintaining routine is a key component of retaining their independence.

In other circumstances, this will not be possible and a move to another setting, such as a care home or community hospital, may be required.

Whether Intermediate Care is provided in a person's home, or in another setting, good communication and a smooth 'handover' with mainstream services is essential. Good links and information sharing needs to be established with the wider infrastructure of community health and social care services, in particular:

- Homecare services;
- The care home sector;
- Day care;
- District Nursing & GPs;
- Pharmacists
- Voluntary organisations; independent providers and social enterprises
- Community mental health teams
- Geriatric assessment services

Accessible, flexible and responsive

Access to Intermediate Care should be speedy and as direct as possible, avoiding multiple referrals or complex pathways. This is particularly important where the focus is preventative and where any delay could prejudice the ability to achieve the desired outcome.

For the same reasons, access needs to be 7 days a week, and 24 hours a day. The ability to reduce the need for emergency admission to hospital would be seriously compromised without this 24/7 access. This does not mean that all Intermediate Care services have to be available: simply that a person can be referred and their immediate needs met 24/7.

People will 'enter' Intermediate Care from a multitude of different points in the local health and social care system. The main sources of referrals are likely to be from:

Clear information for the individual, their family and carers is also essential including:

- Signposting to appropriate future services, either from statutory organisations or the third or independent sector.
- Advice and training on self care and management of long term conditions
- Follow up support should be identified, other agencies contacted and involved in the ongoing care needs.

- Entry and exit points to acute hospital, including A&E, Admissions Wards, and those planning discharge
- Mainstream community based services, such as home care, district nurses or GP practices
- Emergency services, such as the out of hour's service and the Scottish Ambulance Service.

These are likely to be the most immediate referral points: however routes may be more varied and complex. For example, there may be referrals from the homeless team or Mental Health services. Key to making the system accessible is to minimise the number of contacts which a person needs to make before accessing Intermediate Care.

There is no 'right' design: rather it needs to reflect and incorporate the local health and social care system.

Most of the routes into Intermediate Care are **reactive** responding to contact being made as the result of a change in needs or circumstances. However there are approaches which are more **proactive** in nature such as discharge planning to identify people who might be suitable for Intermediate Care; and systematic review of emergency respite placements and anticipatory care planning.

The particular issue about avoiding unnecessary admission to hospital has led a number of areas to develop 'admission avoidance services' located physically at the point of entry into an acute ward: within A&E and the Medical Assessment Unit.

The emphasis of these teams is to develop an overall picture of the person in a wider social and health context and not just focussing on the immediate reason for presenting to hospital.

Because of the wide range of different needs and the multiple pathways that people will follow, there are significant benefits in establishing a **single access point** for all those who may benefit from Intermediate Care. This provides a clear 'route in' to Intermediate Care, which can be widely publicised within the local health and social care system, and to the general public. It also enables there to be consistency in the assessment process and service delivery.

Holistic assessment around personal outcomes

At point of access to the local Intermediate Care system, the individual's needs and priority level should be identified quickly and passed to an appropriate responder. Algorithms can be developed and effectively used to do this. This must be supported by assessment processes which are fair and consistently applied across the partnership area.

The Self-directed Support (Scotland) Bill will place a duty on councils to offer choice to all people eligible for support under the Social Work (Scotland) Act 1968. It is expected that this stage will be at the conclusion of a period of Intermediate Care (IC). In circumstances where the provision of IC is provided under the 1968 Act then these duties will apply from the outset.

Any assessment for IC should sit within the local partnership's approach to outcomes and sit within the partnership's wider approach to personalisation, offering:

- **Personalisation as prevention** – services that are designed to build the capacity of individuals and communities to manage their own lives with appropriate and proportionate intervention at the right time.
- **Personalisation for people with complex support needs** – help people to find the right support solutions for them and to be active participants in the development and delivery of services.
- **Personalisation as choice** – sometimes people just want to have efficient, reliable "off the shelf" services which respond to their needs when they have them.

Assessments should be holistic and related to the individual's needs and the personal outcomes they seek. A number of example assessment tools, developed by local partnerships, are available on the Joint Improvement Team's website at <http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/sample-tools/>.

Key amongst these is **Talking Points**, centred on three frameworks of outcomes, one for people using community services, one for unpaid carers, and one for care home residents. The care homes framework was recently developed, following a pilot exercise in three care homes in the Scottish Borders. A report of the pilot is available on the JIT website at <http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/>.

A key issue in assessment for Intermediate Care is whether or not the person is medically ready for Intermediate Care – the issue of 'medical stability'. There are particular challenges in relation to older people with cognitive problems, where it is particularly important that skills are re-established within the familiar home environment but who may present with a complex set of medical problems. There are also challenges in relation to people with other mental health problems, such as depression. Acute care at home offers particular advantages for people in these circumstances.

Coordinated, multi-professional and multi-agency

Intermediate Care needs to be able to draw on expertise from a wide range of services including health, social care, housing and from the public, independent and third sectors. An effective local Intermediate Care system requires effective co-ordination of this wide range of service inputs; it also requires a capable workforce.

Coordination

There are two levels at which coordination of Intermediate Care is needed

- (a) System level coordination (strategic)
- (b) Coordination of the individual's Intermediate Care package (operational)

The effectiveness and quality of the local Intermediate Care system will be undermined if there is insufficient **system level coordination** – arrangements must enable multi agency and multi professional inputs to be secured at the point at which the individual needs them. Most local Partnerships will decide to have some dedicated intermediate care services, particularly to provide the core coordination and assessment functions; but it will still be necessary to pull in wider service contributions to create integrated and holistic packages for people, especially those with complex needs.

Effective system level coordination requires:

- Promotion of the services and provision of information to both staff, and users and carers
- Pathways, protocols and eligibility criteria for access to services (including the Scottish Ambulance Service)
- Agreement between agencies and organisations which will contribute to Intermediate Care – the statutory, independent and third sectors; primary care, community care health services, social care, housing and the acute sector.
- Effective leadership and champions to challenge historical ways of working and resource allocation.
- Funding of Intermediate Care, and arrangements for use and distribution of this funding
- A process for resolving any disputes or difficulties.

While agreement on these issues should be set out in writing between the partners, so that there is a shared and widespread understanding of role and responsibilities, it is important not to hinder the development of Intermediate Care by a lengthy negotiating process.

The multiplicity of different pathways, circumstances and needs amongst those who will use Intermediate Care has led many local partnerships to appoint an **Intermediate Care Coordinator**^{xviii}.

Partnerships who have not already done so should consider jointly appointing a dedicated Intermediate Care co-ordinator (or co-ordination team). The role of the Intermediate Care co-ordinator will vary, depending on what services are already in place locally, the degree to which they are

integrated, and the numbers, skills and experience of staff. The co-ordination function must operate at both strategic and operational levels. Some areas with complex organisational structures may need more than one person to ensure that all tasks are performed.

Individual case coordination is also required so that people experience an integrated package of interventions. Dedicated intermediate care services are likely to provide certain core services within the local system: however the range of complex needs, and the varying personal outcomes that people will seek, inevitably means tailored packages of care.

It is essential that one person co-ordinates the response to all care needs and develops a multi-disciplinary treatment plan which can draw other services. This treatment plan should be communicated, implemented, monitored and reviewed.

Multi-professional, multi-agency skills

The need for integrated services brings with it a requirement for staff to be flexible and responsive. This is recognised as a key component of the Reshaping Care programme and reflects earlier policy documents and workforce development supported by NHS Education for Scotland and JIT. [Capable, Integrated & Fit for the Future: A Multi-Agency Capability Framework for Intermediate Care](#)^{xix} sought to encourage a

“...capable workforce that has the skills to support better health, better care for older people and people living with long term conditions. It helps build an integrated workforce that is fit for the future and helps people realise their full potential for health, independence and wellbeing.”

In planning tomorrow's workforce today we need to take a more integrated approach to developing the capability of staff.. This includes extended roles for staff and more collaboration in creating development opportunities across care settings and sectors. Developing the workforce in acute, primary and community care settings is vital to delivering a shift towards community based services which are modern, safe and sustainable and give better and faster access to care locally.

In today's climate tasks are being delegated to more appropriately trained staff, freeing up the time of higher qualified staff to undertake more specialised work^{xx}. The appropriate use of skilled support workers can improve the continuity and experience of care, bridging the gap between health and social care by combining social care with rehabilitation skills^{xxi}. However to successfully achieve this task delegated, support workers require appropriate training in rehabilitation and re-ablement and confidence to know when they have reached the limits of their capability^{xxii}.

Partnership Example of Good Practice

STARS (Short-Term Augmented Response Service) staff training NHS Dumfries & Galloway

STARS provides a 6 month, intensive reablement training course "Promoting self management, enablement and rehabilitation at home" for support workers. The course content is delivered by health and social care practitioners/professionals dedicated to improving support worker role development and delivering quality reabling services to service users.

The overall aim of this training and development programme is to enable Health and Social Care Support Workers (HSCSW) to develop and evidence effective knowledge and practice skills which can be used particularly within the home environment to promote service user self management, enablement and rehabilitation, under the direction of registered appropriate professionals. Learning is levelled at Scottish Credit and Qualification Framework (SCQF) Level 6 in line with the NHS Career Framework and Social Services role requirements to promote quality assurance and support regulation agenda. The training package is in the process of being accredited formally at SCQF6 to meet the needs of health and social care support workers and at the final phase of the validation process within the Scottish Qualification Authority (SQA) in partnership with Scotland's Colleges led by Dumfries College to become a nationally recognised National Progression Award (NPA).

To date 75 support workers have enrolled, ranging from nursing auxiliaries, physiotherapy assistants, occupational therapy assistants, generic health care support workers, social care support workers and mental health assistants. Students gain training from nursing and allied health care professionals from health and social care backgrounds as well as hearing from a service user guest speaker about the experience of managing a long term condition. Interactive learning includes presentations, practical skills lab and e-learning opportunities. Support worker are asked to evaluate their scope of skills, knowledge and confidence upon enrolment and then upon completion of the training have all reported improvements ranging from initial 'limited' or 'basic' to 'developing' or 'competent'. Support workers comments upon completing the course have included:

Participants Feedback:

- "I thoroughly enjoyed course definitely improved my confidence and ability to do my job better and maximise opportunities to support service users to live as independently as possible"
- "Folder is a good learning tool to recap on conditions, effect on every day life and strategies to help"
- "Understanding different professional roles and the practical classes helped consolidate my learning – thank you to all who took time out to support our learning and development"

Further information is available from Gail Edgar, STARS Service Manager or Wendy Thomson, OT Development Facilitator and Programme Lead, STARS on 01387 241500.

Managed for improvement

Managing for improvement involves understanding the contribution that Intermediate Care makes at 3 interlinked levels

- (a) For the individual using the services
- (b) For the local Intermediate Care system
- (c) At whole system level.

Impact at the level of the individual needs to be able to capture **personal outcomes** and the 'distance travelled' by the individual during the period that they received Intermediate Care: what improvements in quality of life has Intermediate Care enabled the individual to achieve? This requires gathering information on the individual's position at 'entry' to Intermediate Care, and comparing this to the position at 'exit'. The use of outcomes based evaluation tools, such as Talking Points, provide a useful framework for this process. Data on distance travelled needs to be related to service inputs to inform service improvement.

Care needs to be taken in the interpretation of the data captured at individual level. 'Success' cannot simply be considered as the greatest distance travelled for the least service input – this will hide the huge variety of needs and capabilities amongst those using Intermediate Care. Success for one person may be the ability to be able to stand unaided again – while for another with similar abilities at the outset, it may be the ability to be able to walk upstairs.

A challenge for the **Intermediate Care system** is that its performance will depend in large part on the effectiveness of contributions made by other services. The development of standards, and the associated indicators, to assess these contributions will be key to gathering information for service improvement.

For example, good practice standards and indicators may be to:

- Develop written service objectives which are widely communicated to all stakeholders.
 - ♦ Are there clear service objectives?
 - ♦ How are these communicated?
- Develop service standards for Intermediate Care, and for the assessment and provision of the services.
 - ♦ Are there service standards in place?
 - ♦ How/when are these monitored?
- Agree a concise range of performance indicators with key stakeholders and use to monitor effectiveness in all areas of Intermediate Care. These should include response/delivery times, business efficiencies, service demand, complaints, training and the outcomes for the individual.
- Has the service identified performance indicators?
- Are these effective in evidencing service improvement?
- How will the information gathered from service users inform this wider service level assessment?

Intermediate Care should also be considered as part of the wider **whole system level** measurement, particularly in relation to the prevention, efficiency and well-being agenda. It should be expected to contribute to wider system level improvements in delayed discharge and emergency admission bed day rates.

In line with the recommendations from the Delayed Discharge Expert Group [report](#) a new target has been introduced to further reduce the number of delayed hospital discharges:

- ♦ **28 day** maximum wait for discharge to be achieved by April 2013;
- ♦ **14 day** maximum wait by April 2015.

Health and social care partnerships are also now required to monitor the number of bed days lost through delayed discharge. Local trajectories could be set by local partnerships to reduce the number of bed days lost. Making effective use of Intermediate Care services, will over time reduce the level of patients delayed, and the length of these delays.

Partnership Example of Good Practice Highland inter-agency working

The multi-disciplinary/agency team, including primary & secondary care, social work and home care, work together to support the acute & community hospitals by providing quick access to step down beds in a local care home. The MDT also provides a hospital at home service, with consultant input and can spot purchase home care to speed up access to the service, and facilitate timely discharge from hospital.

This multi-agency approach has seen improvements through the reduction in bed days lost (saved 354 bed days over a 12 month period) and increased throughput.

Commissioning

The Reshaping Care for Older People Programme asserts that good Joint Commissioning Strategies are essential if partnerships are to achieve a significant shift in the balance of care away from institutional settings towards community settings.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

Joint commissioning is where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget.”.

With an ageing population and diminishing resources Councils and NHS Boards will need to ensure that joint decisions are taken around the management of mutually committed resources such that investment and disinvestment in health and community care services are effectively planned and coordinated.

The Scottish Government signalled to local authority/NHS Partnerships in the 2011/12 Change Fund guidance that future years plans should take the form of Joint Commissioning Strategies. These Strategies and associated governance arrangements provide an opportunity for the Third and Independent sectors and carers to become fully embedded in and strengthen the planning arrangements established during the first year of the Change Plans.

We have established a National Steering Group on Joint Strategic Commissioning. This group will set the direction for strategic commissioning in health and social care nationally in order to assist local partnerships with the formulation of local commissioning plans. In addition, we are developing a National Learning Framework to provide a longer term structured approach to support and learning. This Framework seeks to underpin a national approach to strategic commissioning by identifying the learning needs of partnerships, and by building capacity to deliver cogent and consistent outcome based commissioning in Scotland. The purpose of the Framework is:

- to provide a comprehensive, consolidated picture of current activity to support practice improvement and learning across all aspects of joint strategic commissioning.
- to identify gaps in current activity and arrangements.
- to develop a framework for action to address the identified gaps and weaknesses.
- to promote positive, creative interplay between stakeholders and sectors in order to maximise the impact of the specified learning.

The JIT have developed a number of useful guides to help partnerships through commissioning processes, and are available on the internet at: <http://www.jitscotland.org.uk/action-areas/commissioning/>.

6. Specific Services and Functions

As noted previously, Intermediate Care is an umbrella term that refers to a set of functions and services which share a common purpose – creating a bridge between the person's home and hospital / care home settings.

This section aims to provide more detail and further examples of Intermediate Care including the work of the Intermediate Care Demonstrator sites.

Triage, Early Diagnosis and Assessment

Important principles of an Intermediate Care system are prompt, safe and effective streaming to the appropriate acute care /service within the wider Intermediate Care system.

Access to Comprehensive Geriatric Assessment (CGA) for frail older people who will have greatest benefit is highly desirable. Randomised controlled trials of CGA show that organised care in Medicine for the Elderly wards increases the proportion of older people who return home from hospital, reduces length of stay, death and permanent care home outcomes. The effective triage at the onset of an acute episode plays a significant part in determining the subsequent journey of care and the outcome^{xxiii}.

Compelling evidence for specialist led co-ordinated assessment and rehabilitation in acute care may have contributed to a reluctance for specialist older people teams to embrace community based alternatives. However, the reality is that many frail older people admitted to acute hospitals still do not access CGA, but are cared for in general medical wards.

Effective multidisciplinary care in the right setting through Consultant Geriatrician led community services, is a key component of the Intermediate Care system. The Torfaen Advanced Clinical Assessment Team provides a clear illustration of the benefits of rapid specialist assessment and diagnosis in the community. This team manages the person's care at home for between 24 hours to 14 days depending on the complexity of the care needs^{xxiv}.

Partnership Example of Good Practice East & Midlothian assessment beds

East Lothian has a number of 24/48 hour assessment beds, used to help prevent admission to hospital from home.

Similarly, Mid Lothian has developed a number of Intermediate Care beds which 'pull' patients from hospital (when suitable), giving them additional time to recover and receive appropriate rehabilitation, before returning home.

Acute Care at Home

Many terms have been used for this type of service, most commonly a Virtual Ward or Hospital at Home. Effective triage and assessment will determine whether a person is able to remain at home or will require acute care in hospital. Continued assessment and diagnosis is a key component of any acute care in the person's home and to be most effective must be well integrated with primary and secondary care and the wider Intermediate Care Team. A key feature of this component of Intermediate Care is the ability to deliver technical interventions e.g. intravenous antibiotics in the person's own home.

Other features are specific to particular medical conditions e.g. pulse oximetry or Chronic Obstructive Pulmonary Disease (COPD). General features are the co-location of key members of the team and full integration with the wider system. More recently services have shown the benefits of this approach also with dementia. In this example, teams provide rapid multi-disciplinary assessment and treatment in the person's own home working alongside the carer to resolve crisis without hospital admission. The average time of care given at home was 6.6 days but provision was made for interventions up to 6 weeks. This is an important development given that dementia is often associated with delayed discharge.

Intermediate Care Demonstrator Project

Perth & Kinross Transitional Care at Home Team (TCAHT)

The project

Assessment carried out within acute service admission wards (Ward 4, 7 & 8) to identify patients presenting with cognitive impairment / dementia and / or delirium and who may benefit from an early supported discharge service supported by the TCAHT comprising of a Transitional Care Nurse and three Social Care Officers with a special interest in dementia care.

This team had access to other professionals who provided support, advice, and assessment e.g. pharmacy, occupational therapy, physiotherapy, community nursing, Community Psychiatric Nurses (CPN) and psychiatric consultant. The Transitional Care Nurse was available Monday to Friday 8.30 am to 4.30 pm and the Social Care Officers provided a service 7 days a week from 8 am to 10 pm. Links were made with out of hour services such as community alarm, evening and overnight community nursing, social work services, mental health services etc.

Fourteen patients were accepted on to the TCAHT during the time period June 2009 to January 2010 from acute sector wards. The minimum length of stay was 4 days and maximum 23 days. The average length of stay was 11 days with a median length of stay of 10 days. There were no delayed discharges.

A full report from the Perth & Kinross Demonstrator Project is available to download at <http://www.jitscotland.org.uk/action-areas/intermediate-care/>

Multi-Disciplinary Rapid Response Community Teams

These teams are more commonly associated with the term Intermediate Care and can often also be called Rapid Response Teams, Community Rehabilitation Teams and Integrated Response Teams. The key principles of these teams is to provide a “wrap around” service for patients including a key worker, community rehabilitation assistants and access to a range of professionals across Health and Social Care.

These teams and services will tend to form the largest part of any Intermediate Care system, with the Allied Health Professions having a central role in design and delivery of care.

The main restrictions reported relate to out of hours services and 7 day working, as well as the need to have clarity regarding any overlap and links with other community services e.g. community nursing.

Partnership Example of Good Practice Dumfries & Galloway STARS

Stars is a joint NHS/local authority project which provides a single augmented response service across Dumfries & Galloway. Previously, several augmented/rapid response services existed, all providing a very similar service but with different budgets and different management structures. In addition, these services were not able to cover the whole of Dumfries & Galloway and there were significant gaps in provision.

The Short-Term Augmented Response Service (STARS) was developed as a joint initiative between the NHS and Council in 2005. The services aims to:

- Facilitate safe discharge from hospital at the earliest possible stage;
- Avoid unnecessary admission to hospital; and
- Prevent premature dependence on long-term care.

Enhanced Supported Discharge

There is now extensive experiential and trial evidence to support community based models for post acute care and rehabilitation, including early supported discharge. This is most powerful in relation to stroke and hip fracture. Involvement of the Voluntary Sector can also be a feature of this service area.

The Intermediate Care Demonstrators in Orkney, Perth and Kinross and Fife all reported the positive impact of the multi-

disciplinary teams on length of stay in hospital, prevention of admission, functional outcomes and experience of service users.

The main limitations reported relate to out of hours services and 7 day working, as well as the need to have clarity regarding any overlap and links with other community services e.g. community nursing.

Partnership Example of Good Practice Enhanced Supported Discharge, Edinburgh Royal Infirmary

As part of the development of transformation plans under the Change Fund an Enhanced Supported Discharge team was established within Edinburgh Royal Infirmary. The team provided rehabilitation and re-ablement through AHPs, healthcare assistant and social care assistants to support discharge from acute medicine for the elderly, general medicine, stroke and respiratory wards in ERI.

The service was set up as a 7 day service, delivering care for up to 7 days per person, with a flexible approach on an individual basis. During the pilot 24 patients were supported resulting in:

- 109 bed days saved
- Reduction in average length of stay from 9.4 to 5.2 days
- Length of service provided in transition from hospital to community ranged from:
 - 1-5 days 57%
 - 6-10 days 33%
 - 11-14 days 10%

Example of Good Practice Age UK Warwickshire 'Gateway'

In 2009 Care & Repair England began work on its *'if only I had known ...'* programme to improve housing related help in hospital settings. Three areas were selected to pilot this work, one of which was **Warwickshire Age UK and Coventry Care & Repair**.

Hospital advice and information provided through leaflets and advice workers has developed into the Age UK Warwickshire 'Gateway' service, a call centre for assessment and referral. The aim is to support older people and vulnerable patients who would benefit from practical and social support. The provision includes housing related advice, information and practical help.

The scheme is particularly focused on discharge and helping minimise the risk for readmission. Needs are identified through Age UK Warwickshire advice and information staff in hospitals, and/or Gateway staff through phone calls and follow up home visits (where judged necessary). Individuals are referred on to an appropriate service provided by Age UK Warwickshire or other local groups, including Care & Repair agencies.

Key impact to date:

- Patients, hospital staff and carers have better, timelier access to information and advice about practical and social support, including for housing
- More needs are being met, and met quickly. The number of referrals from hospitals is increasing. Patients who agree to be contacted after they return home have been contacted within one working day of discharge
- More housing related issues are being dealt with:
 - A high percentage of all referrals include a housing/handyperson element.
 - Rugby Care & Repair developed a closer relationship with the discharge co-ordinator, nurses and OTs at Rugby St Cross hospital during the initial project. This has meant an increase in hospital referrals.
- Two of the eight hospitals that cover the county are working with Age UK Warwickshire to expand available support.

Further information on this and other schemes are available in the report *If only I had known... Integration of housing help into a hospital setting* and accompanying evaluation. Both these reports are available on the internet at <http://www.careandrepair-england.org.uk/reports.htm>.

Community Hospitals and Care Homes

Following admission to Acute care, frail older people frequently have a long length of stay within the acute sector. Where discharge home is not possible, then Community Hospitals can play an active role in the ongoing rehabilitation and recovery particularly of frail older people.

Although Intermediate Care is primarily a home based service model, for some people it is not possible to deliver Intermediate Care in the home environment. In this case a Community Hospital or Care Home, can provide a homely, holistic and effective environment for recovery closer to home.

Partnership Example of Good Practice Intermediate Care Beds; North Lanarkshire

North Lanarkshire Council and NHS Lanarkshire piloted Intermediate Care beds within two care homes – Belhaven and Leslie House. The pilot has led to two adapted care homes being developed at Muirpark and Monklands House care homes (centres). The two care centres provide a total of 21 beds – 7 Intermediate Care; 6 Respite, and 8 for emergency situations.

The initial pilot was successful in preventing hospital admissions and in reabling people as part of a safe return from hospital, most often from A&E and emergency receiving beds.

Partnership Example of Good Practice Links Unit, City Hospital Aberdeen

The Links Unit is a nurse-led Intermediate Care Service provided within a hospital setting. Patients can be admitted directly from A&E, or other hospital ward or by a GP in the community.

- The service aims to maximise the individuals potential for recovery, and ensure, wherever possible the person returns home.
- An estimated date of discharge is agreed by the multi-disciplinary team, including the patients doctor, and AHPs.
- Nurse makes decisions on who is admitted, ensuring most effective use of available beds.

**Partnership Example of Good Practice
Angus Independent Intermediate Care Scheme (IICS)
Carnie Lodge, Arbroath**

The Angus IICS is a stepping stone between hospital and home designed to help people move out of hospital quicker or to avoid an admission to hospital. People are assessed either at home or in a hospital and if appropriate, they are offered a place within a care home, with stay varying in length depending on need.

A range of support and rehabilitation services are available including physiotherapy, occupational therapy and 24 hour nursing care. Weekly review meetings are then held with all staff involved in the persons care to monitor progress and need, and make plans for them to return home – this is done in partnership with the person, their family and carers.

Since the service began in 2003/04 228 people were assessed and accessed the service from home, and 279 from a hospital setting.

NHS Pharmaceutical Care in the Community

NHS pharmaceutical care should have a prominent place in the provision of intermediate care, with pharmacists having an integral role in pathways of care and the processes underpinning it. This will be increasingly important as new models of care are developed as part of the wider vision and national outcomes for adult health and social care integration.

As we continue to see changes in the way in which care is provided, and shifts in the balance of care from hospital and other institutional care settings, it is recognised that there are significant opportunities for NHS pharmaceutical care to support people to live independently at home (or in a homely setting) through better supported self care and medicines management.

Local initiatives, such as the development of the 'virtual ward' and 'intermediate care demonstrator' projects in Fife, which are of continuing policy interest to the Scottish Government, will help to inform national approaches to the role of pharmacists and the pharmaceutical care they provide as key partners in the provision of intermediate care and care at home.

The outputs from these and other initiatives will be considered in conjunction with the conclusions and recommendations of the *Review of NHS Pharmaceutical Care of Patients in the Community* which is to report in October 2012.

Falls Prevention Services

Older people admitted to hospital after falling are more likely to be discharged to a Care Home than a comparative group of people admitted for any other reasons (*Gilbert et al 2010*). There is evidence that having a clear falls prevention strategy and a dedicated service in place as part of the Care Pathway reduces emergency hospital admission (*Rose et al 2002*).

The Cochrane review of interventions preventing falls in older people in the community (*Gillespie and Handoll 2009*) showed that these could reduce overall care costs by preventing hospital admissions. Successful interventions included group and personalised home based exercise programmes for strength and balance training.

Partnership Example of Good Practice Edinburgh Falls Emergency Pathway

A partnership between the Scottish Ambulance Service (SAS), Edinburgh CHP (Intermediate Care, Community Alarm and Telecare Service (CATS), Social Care Direct, Primary Care) and NHS 24.

The SAS is now able to make referrals for the following falls services:

1. Alternative to conveyance to hospital

The SAS crew can complete an agreed falls protocol that will guide a decision towards whether a person requires to be conveyed to hospital or whether accessing a team that can carry out an urgent assessment at home is a more appropriate option. The crew can contact a call handler (in hours and out-of-hours) directly from the house to discuss the person's needs and options for assessment. The Rapid Response teams (Intermediate Care) in Edinburgh provide assessment and rehabilitation on same or next day to prevent unnecessary admission to hospital. An Occupational Therapist and Physiotherapist carry out an urgent assessment in the patient's home and arrange support and intervention as required for up to 5 weeks. The person can also be supported with a telecare package, including a response service.

2. Multifactorial Falls and Fracture Risk Assessment

The SAS crews can use the same falls protocol to refer for falls assessment and intervention targeted at modifiable risk factors, provided by intermediate care teams within 7-10 days, for those who have had a fall and are at high risk of further falls.

3. Fallen Uninjured Person Pathway

If a 999 call is received by SAS the paramedic advisors can direct the referral to the Mobile Response Service (CATS) who will go out to assist the person and refer on for falls assessment and telecare package as required.

Home Care Re-ablement

Initial research suggests that a home care service with a re-ablement philosophy is an effective and efficient alternative to the traditional model and is associated with improvements in health of the people using the services, with a high level of user satisfaction, staff involvement and commitment.

Re-ablement within Home Care services was first introduced by the City of Edinburgh Council in one area of the city in October 2008 and subsequently rolled out into other areas.

The Scottish Government commissioned an independent evaluation of the service during its first 8 months of operation - October 2008 to June 2009^{xxv}. The main findings were positive staff and service user satisfaction, reduction by 41% in the number of home care hours a person required after the re-ablement period, and 2/3 of those whose hours reduced required no further service at the end of the re-ablement period. These findings are similar to English and Australian studies^{xxvi}.

Partnership Example of Good Practice Cumbernauld Re-Ablement Service

The aims of the Reablement programmes are to assess service users' functional ability within their homes, to maximise service users' independence with activities of daily living and if an on-going home care service is required at the end of Reablement to recommend an appropriate service based on evidenced need.

The Cumbernauld Reablement Team consists of:

1 FTE Occupational Therapist.	2 FTE Home Support Managers.
1.5 FTE administration workers.	15 Home Support Workers.

The Reablement team works with CARS team, North Lanarkshire hospital discharge team, to maximise service users' independence within their own homes. They are developing links with North East Rehabilitation Service, Glasgow hospital discharge team.

Upon receipt of referral OT and Home Support Manager visit service users at home to complete an initial Reablement Assessment, establish service users' outcomes and to set goals with service users. Weekly Reablement Team Meetings are held to discuss service users' progress and set new goals. The Reablement team also have twice weekly handovers to discuss any issues arising, discuss new service users etc.

Outcomes

- 118 service users completed the re-ablement programme between October 2010 and September 2011.
- No service users hours increased
- 21 service users (26%) hours decreased

Services for people with Dementia and Other Mental Health Conditions

Depression, anxiety disorders and dementia are associated with well documented adverse outcomes for older people including increased rates of admission to hospital, increased length of stay in hospital and higher rates of institutionalisation^{xxvii}.

A study by Shah et al in 2000^{xxviii} in a generic rehabilitation unit for older people, found that only 42% of patients were free from clinically significant symptoms of anxiety, depression or cognitive impairment. There is a real risk that if their psychological needs are not adequately addressed the person may not achieve the rehabilitation outcomes they desire.

The prevalence of dementia and other mental health problems is sufficiently high that all Intermediate Care services should be able to respond positively to patients with these conditions. A number of the Demonstrators^{xxix} highlighted positive results from linking with Old Age Psychiatry services and Clinical Psychology, as well as extending the skills of staff working in Intermediate Care services to manage the wide range of conditions that commonly present in older people

Partnership Example of Good Practice Early Supported Discharge Team for stroke & orthopaedics

Focuses on patients with elderly care needs and the work of wards 11 & 12 of Aberdeen Royal Infirmary to reduce length of stay within Care of Elderly wards. Starting in the Acute Medical Admissions Unit (AMAU), with a treatment plan that follows the patient, utilising psychiatry services to aid discharge and liaise with community services appropriate to the assessed needs, wherever possible with the aim of discharging the individual back to their own home.

Data available on number of assessment in AMAU, and throughput.

7. Service Design and Delivery

The description of any service usually makes more sense when presented from the perspective of the people who will use it. When expressed in this way, the design more easily meets an agreed range of needs and positively contributes to rehabilitation, recovery and to carers being able to continue in caring roles.

This section of the framework uses a number of scenarios that illustrate the key responses required to meet personal outcomes, – these are only for guidance and are not exhaustive.

These scenarios should be used to assess current capability and therefore guide local service changes required.

The key questions are:

- What is the service user experience in this area?
- Can the local system meet the personal outcomes described?

These questions and scenarios are not intended to be a substitute for on-going engagement with service users and their families. However they illustrate the key features of successful Intermediate Care through common situations that many will identify with. It is recognised that there are different ways to ensure the outcomes are met and these will differ across the partnerships e.g. city and rural situations may respond in different ways.

The Scenarios

Alice is frail and has a fall at home in out of hours period.

Alice is a 78 year old lady who lives alone and has twice daily visits from home carers to help with personal care. She also has family support close by and a network of friends in the local community. Her home has some adaptations and she has community equipment including toilet frame and personal alarm.

Alice has short term memory loss, is unsteady on her feet and starting to experience falls at home. She also has a history of Urinary tract infections. However she is very much in control of her life and wishes to retain this independence.

Alice had a fall on a Friday evening resulting in a head injury. She did not lose consciousness and calls her neighbour for help. Her neighbour is quick to respond to this incident and calls an ambulance.

The Personal Outcomes that have been expressed by Alice are:

- ✓ To avoid hospital admission
- ✓ To receive best medical care
- ✓ That with her family, she will be fully involved in decisions
- ✓ To be supported to recover fully – “to be as good as she can be”
- ✓ Clear and consistent information that is shared with herself, her family and her GP
- ✓ To have a plan made for any future ill health episode, so that her views are known and any future response is in line with those wishes

How could Intermediate Care respond?

Initial Triage and Diagnosis

- Scottish Ambulance Service, using one access point, have an established care pathway that includes contacting Intermediate Care in OOH period for response and / or advice.
- Pathways are in place to provide a short hospital stay (maximum overnight) to ensure x-ray and other medical investigations are carried out.

Assessment and medical care planning

- Acute Receiving Unit(s) have access to Intermediate Care OOHs to ensure timely discharge.
- The ability to provide home based care and support overnight could include voluntary organisations, independent sector or statutory providers.

Multi-disciplinary Team response

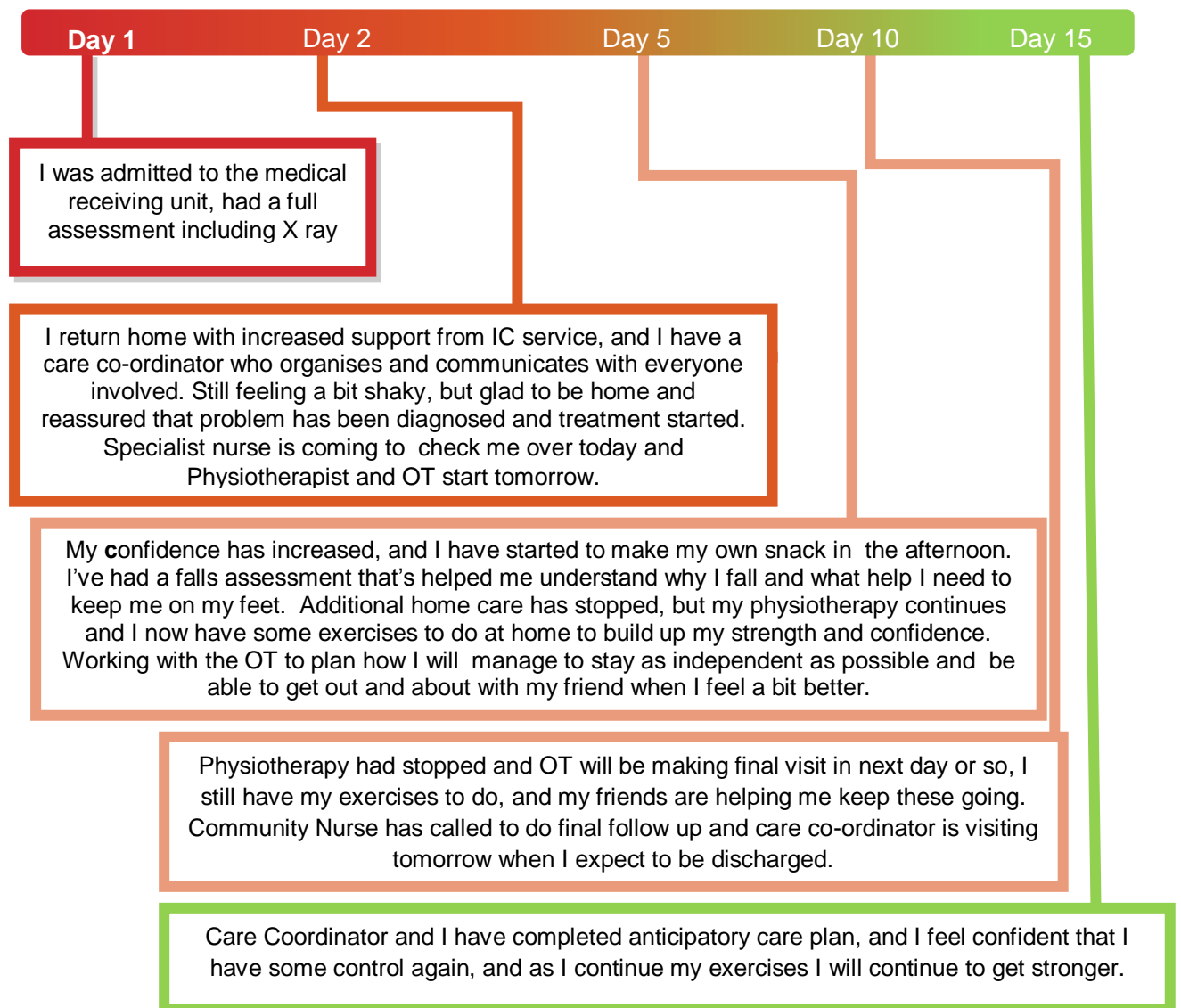
- One person to coordinate care across the whole system, in line with identified needs and family support available.
- Carry out a 'multifactorial falls risk assessment' to identify modifiable, contributory factors to the fall and gather a full falls history. The assessment should consider Alice's mobility; home environment; ability to carry out daily activities; need for medication review; postural hypotension; feet and footwear; vision; fear of falling/reduced confidence, and cognition etc.
- Access to Allied Health Professionals, home care and nursing team, working in an integrated model – enhancing existing care arrangements rather than replacing. This could include re-ablement home care for a short period.
- Medical or specialist nursing follow up closely aligned to wider Intermediate Care Service

“To be as good as she can be”

- Personalised falls prevention programme is developed, based on the risk assessment findings, and specific goals are set, in discussion with Alice.
- Information on falls prevention is provided in an appropriate format. This includes a range of balance exercises that can be done at home or as part of a group, and will continue after the Intermediate Care period has ended.
- Anticipatory Care plan should be put in place taking into account health and home situation based on personal outcomes.

Turn over to read about Alice's journey.

Time line – How was it for Alice?



Turn to page 26 for a [Partnership Example of Good Practice](#) from the [Edinburgh Falls Emergency Pathway](#)

Bobby is an 82 year old identified as being at risk via his PEONY V2

Bobby's GP Practice are part of a 'Virtual Ward' Local Enhanced Service to test and develop a model of early intervention. Bobby was identified through the use of a Risk Stratification Tool – PEONY 2. This scores the GP practice population who are over 40 years and have a long term condition against their risk of unplanned admission to hospital in the coming year. Bobby's score was 19% (medium risk). Patients with risk scores between 14%-23% are the group for whom early intervention can have the best outcome in terms of prevention of unnecessary admission.

Bobby lives alone and following a fall at home and some investigations, his GP became concerned about his medication compliance and felt there was some degree of cognitive impairment. Bobby also suffers from COPD, Type 2 Diabetes and a recent onset of hypertension. His only family are a brother and sister who live out of town; he has no social service input or help at home.

Personal outcomes expressed by Bobby are:

- ✓ To stay in his own home
- ✓ To look after himself
- ✓ Keep his garden

How could Intermediate Care respond?

Multi-disciplinary case review

- A multi discipline/agency review of Bobby's current situation is held in a 'ward round' format using CISCO technology. Those present in the Multi disciplinary Team (MDT) include:
 - Bobby's GP
 - Practice Pharmacist
 - District Nurse
 - Social Work
 - Community Mental Health Nurse
 - Community Rehabilitation – the AHP Team
 - Medicine for the Elderly (MfE) Consultant
- District Nurse (DN) carried out an initial assessment at home and discovered that Bobby was stock piling his medication, and had stopped taking them as he was unsure of their purpose.

Immediate actions

- All old medication was removed from the house
- Practice Pharmacist carried out a level three face to face medication review
- Bobby was referred for a Community Occupational Therapist assessment
- Bobby was keen to consider the Council gardening service
- Welfare / Benefits check

Multi-disciplinary response

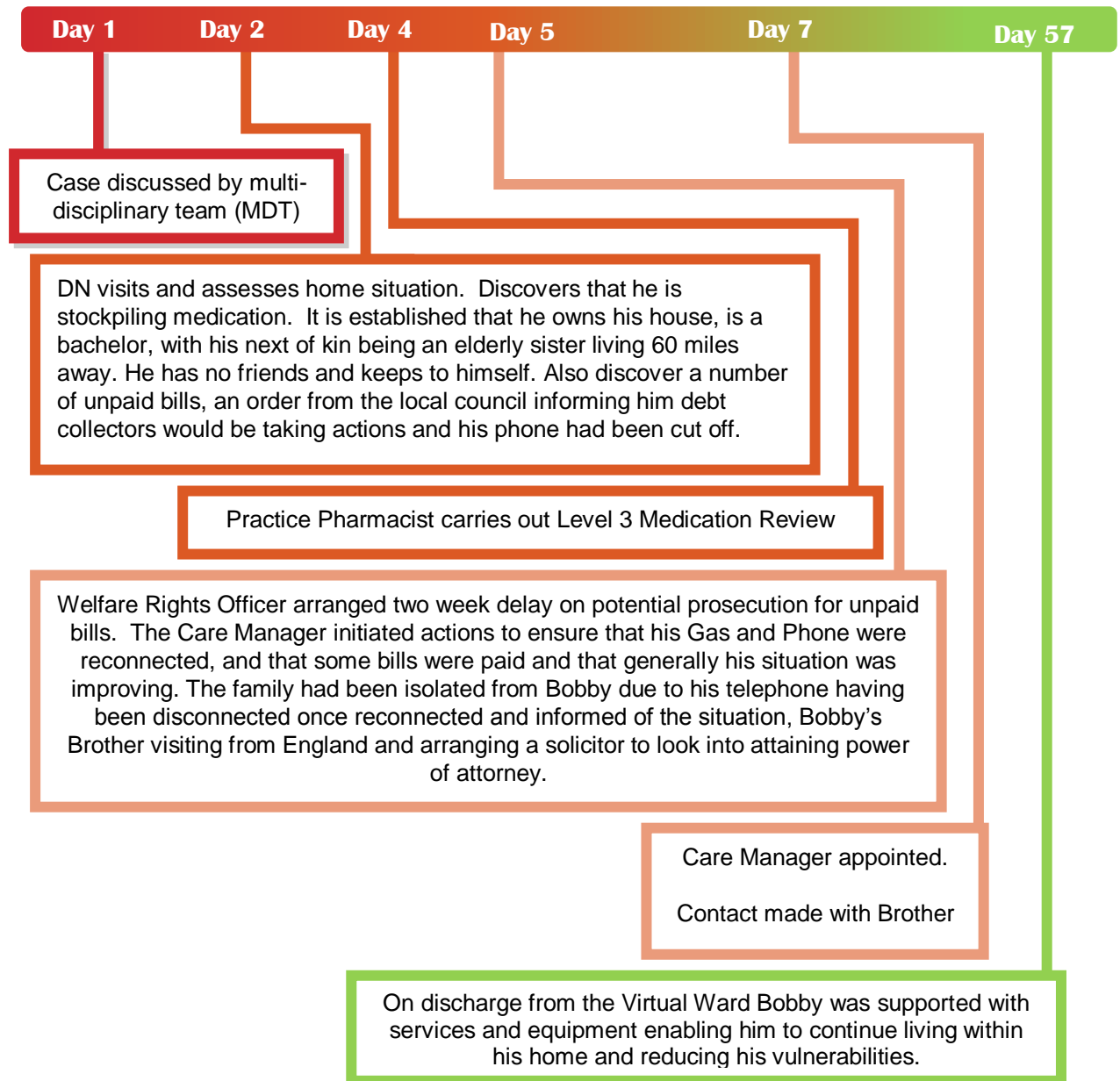
- Practice Pharmacist and DN to monitor Bobby's medication concordance. The outcome of this was that diuretics were commenced and the DN monitored the BP until this stabilised and regularly checked his blood glucose
- The DN arranged to meet a Welfare Rights worker in the home with the aim of gaining information in order to maximise Bobby's income.
- Bobby consented to a referral to social work for assistance with his finances and to other agencies that he would benefit from.
- OT referral resulted in a hand rail for his stairs and bathing aids.
- Meals on wheels service commenced and a Vena link for his medications is now in place and a Key Safe was installed for access into his home. His Brother was successful in gaining power of attorney.

Care Planning

- Bobby has an Anticipatory Care Plan in place, he has discussed his wishes for the future with his brother
- Medication review is completed
- Bobby's Diabetes, COPD & Hypertension will be monitored by the General Practice Team & DN

Turn over to read about Bobby's journey.

Time line – How was it for Bobby?



Partnership Example of Good Practice Dundee Virtual Ward

Dundee CHP and Dundee City Council have worked in partnership to test a model of 'Virtual Wards' with 4 GP test sites.

Medicine for the Elderly and the wider Primary Care teams are working together to identify Older People before unplanned care is required to ensure Polypharmacy issues are addressed, to ensure Anticipatory Care Plans are in place, and that social support is offered to both the older person and their carer.

The learning will be rolled-out as an 'early intervention model' within the wider Integrated Community Services model.

Turn to page 20 for a **Partnership Example of Good Practice** from the [Perth & Kinross Transitional Care at Home Team](#)

Christine is living with Multiple Sclerosis, and is experiencing a period of unexplained ill health and functional decline.

Christine is a 65 yr old, wheelchair bound lady who has been living with Multiple Sclerosis for many years. She lives alone in a remote community, with support. Her daughter lives in Australia. She has homecare visits 4 times each day to help with daily living activities and personal care.

Christine's home has been adapted to meet her needs including provision of equipment. She also visits a day centre once each week.

Her carers start to notice a change in her energy levels and ability to do certain tasks. She also became confused and took the wrong medication on one occasion, after they had been changed by GP. The home care staff decide to call the GP ...

Personal Outcomes expressed by Christine

- ✓ To stay in her own home with the carers who understand her daily routines
- ✓ Have contact with family overseas, ensuring they are involved in care.
- ✓ Not feel so isolated
- ✓ To feel well, and have more energy
- ✓ To have a plan in place should health and function deteriorate
- ✓ To have one person who knows her well and will coordinate care making sure ensure personal outcomes are met.

How could Intermediate Care respond?

Hospital at Home

- Hospital at Home team to can provide a full medical assessment, care plan and follow up treatment or support.

Telecare

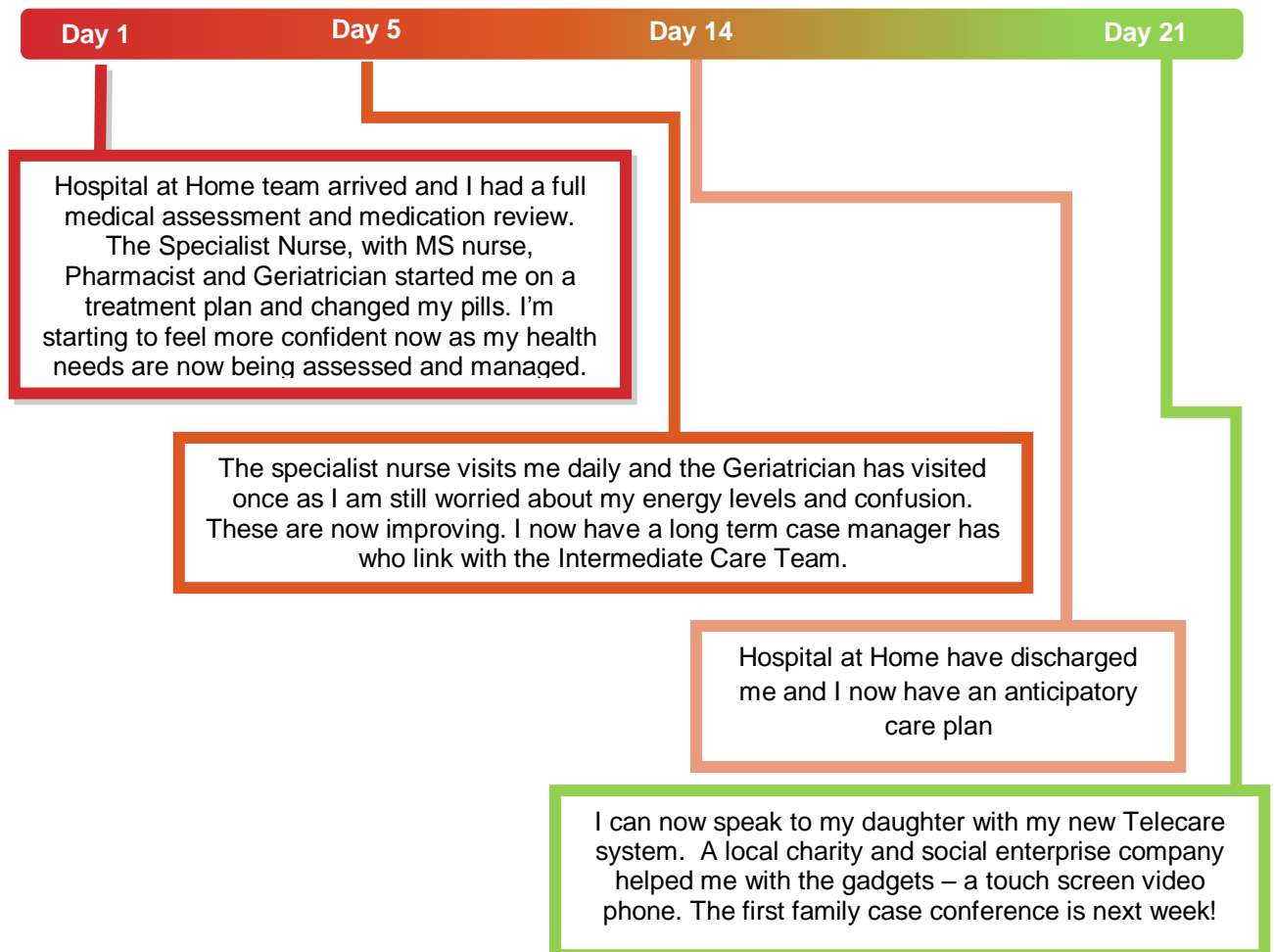
- Telecare solutions can be put in place to ensure contact can be made with her daughter on regular basis.

Anticipatory Care Plan

- A Care Manager is allocated permanently to ensure that a relationship is built, and carries out a full personal outcomes based assessment. This assessment, along with the initial medical assessment is included in the ACP to ensure future care needs are addressed quickly, and in a way that meets desired outcomes.

Turn over to read about Christine's journey.

Time line – How was it for Christine?



Partnership Example of Good Practice DART (Duty & Response Team): East Lothian Council

DART consists of an Occupational Therapist, Physiotherapist, Social Work staff, and Community Care Assistants. The team respond to emergency and urgent referrals with a view to preventing hospital admissions by monitoring individuals at home. Following assessment appropriate advice, care services and equipment is provided within the home, including simple rehabilitation.

Turn to page 21 for a **Partnership Example of Good Practice** from [Dumfries & Galloway STARS service](#)

Daisy is an elderly lady with dementia, who develops an acute health problem

Daisy is a frail 80 year old with dementia. She lives with her 85 year old husband, Bert who is her main carer and is clear that he wants to continue in his caring role without assistance. Their family live close by and want to ensure that their parents stay together, in their own home for as long as possible, but are feeling the pressure of supporting parents without outside help.

Bert has noticed that his wife is becoming more and more aggressive, unsteady on her feet and just seems “unwell”. On one occasion Daisy also tried to leave her home in the early hours of the morning. The family also noticed that she needs more help with daily living tasks.

Feeling that he can no longer cope without help Bert calls his GP at 4pm on a Friday.

Personal Outcomes expressed by Daisy and Bert

- ✓ To be able to stay at home where she feels safe.
- ✓ To feel calm and well again
- ✓ Carer and family feel able to cope
- ✓ Have a plan for the future
- ✓ One contact for the family – someone who knows the situation and they do not have to tell their story to again and again.

How could Intermediate Care respond?

To be able to stay at home, and feel calm and well again

- Hospital at home (Geriatrician and Specialist Nurse) available out of hours through a single access point to assess for delirium. Treatment within the home (including IV antibiotics) can be provided by the hospital at home scheme.
- Access to pharmacy supplies available out of hours, to ensure medication can be provided as soon as possible. Access to psychological support services should also be available as soon as possible, to ensure longer term psychological needs are assessed and addressed.

Carer and family able to cope

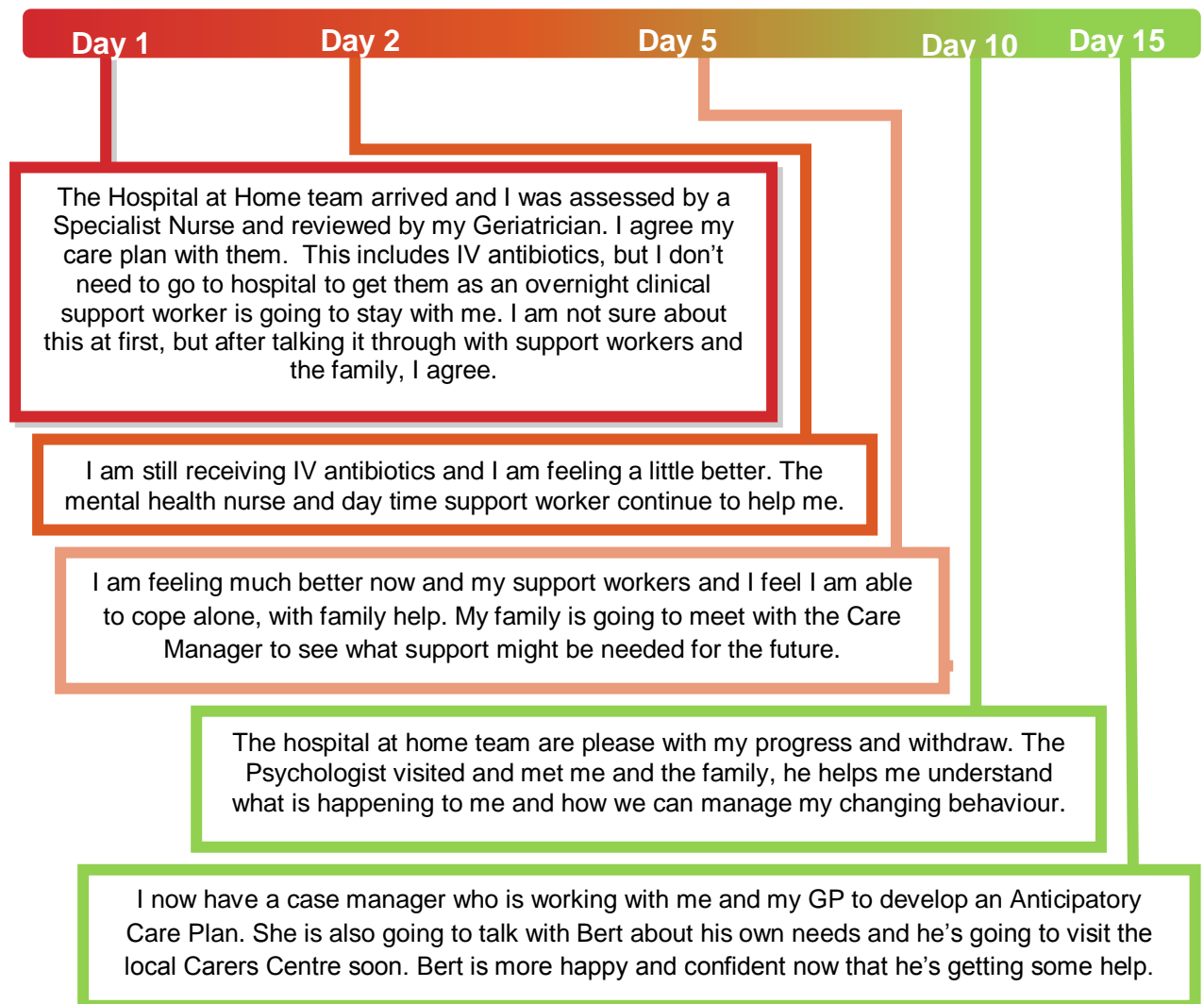
- Overnight care could be provided by suitably experienced home care support staff to provide extra support for family carers. Family also directed to the local carers centre for extra help and support over the longer term.

Have a plan for the future

- A Designated Case Manager keeps contact with Daisy and Bert, and ensure their personal outcomes are met. The Case Manager will also complete an anticipatory care plan, recording all decisions on the Intermediate Care provided, and any longer term care needs, such as psychological support. GP also kept well informed and involved in decision making.

Turn over to read about Daisy & Bert’s journey.

Time line – How was it for Daisy & Bert?



Partnership Example of Good Practice Intermediate Care: Stirling Council

Stirling Council have developed a range of Intermediate Care services under a single management structure. The services include:

- a residential unit within Beech Gardens Care Home;
- rehabilitation at home;
- Crisis care;
- MECS (Mobile Emergency Care Service (Community Alarm)), and
- Therapeutic day care

Service users are able to tap in and out of the different services when needed, and strong links have been developed with assessment and care management teams, providing a seamless delivery of services. All services are outcomes focused and goal driven and are provided jointly by REACH Forth Valley and Stirling Council.

Turn to pages 19, 20 and 21 for further examples of good practice on [East & Midlothian assessment beds](#); [Perth & Kinross TCAHT](#) and [Dumfries & Galloway STARS service](#).

Eddie - is recovering from a stroke, whose housing no longer suits his needs.

Eddie is 70 yrs old, living alone with no immediate family, but with a network of close friends living nearby. He suffered a stroke 2 weeks ago and is recovering in hospital.

Eddie is showing good signs of recovery, but has a right sided weakness, is unable to walk, can sit unaided and is continent. His has speech difficulties but this is improving.

He is expected to continue to improve and is keen to return home as soon as possible.

Eddie's home is currently unsuitable for his needs, requiring major adaptations. Despite this he is keen to leave hospital and continue his recovery and rehabilitation in the community.

Personal Outcomes expressed by Eddie

- ✓ To get out of hospital as soon as possible return to his own home
- ✓ To receive regular therapy to continue recovery and be fully independent again including communication
- ✓ To be in control of his future
- ✓ For personal outcomes known and respected.

How could Intermediate Care respond?

Assessment & Discharge Planning

- A full outcomes based assessment is carried out to establish what options are viable, whilst Eddie is recovering in hospital. A Full Multi-Disciplinary Team, including key worker or case manager, experienced in Stroke rehabilitation are involved from the early stages to ensure best recovery.

Housing

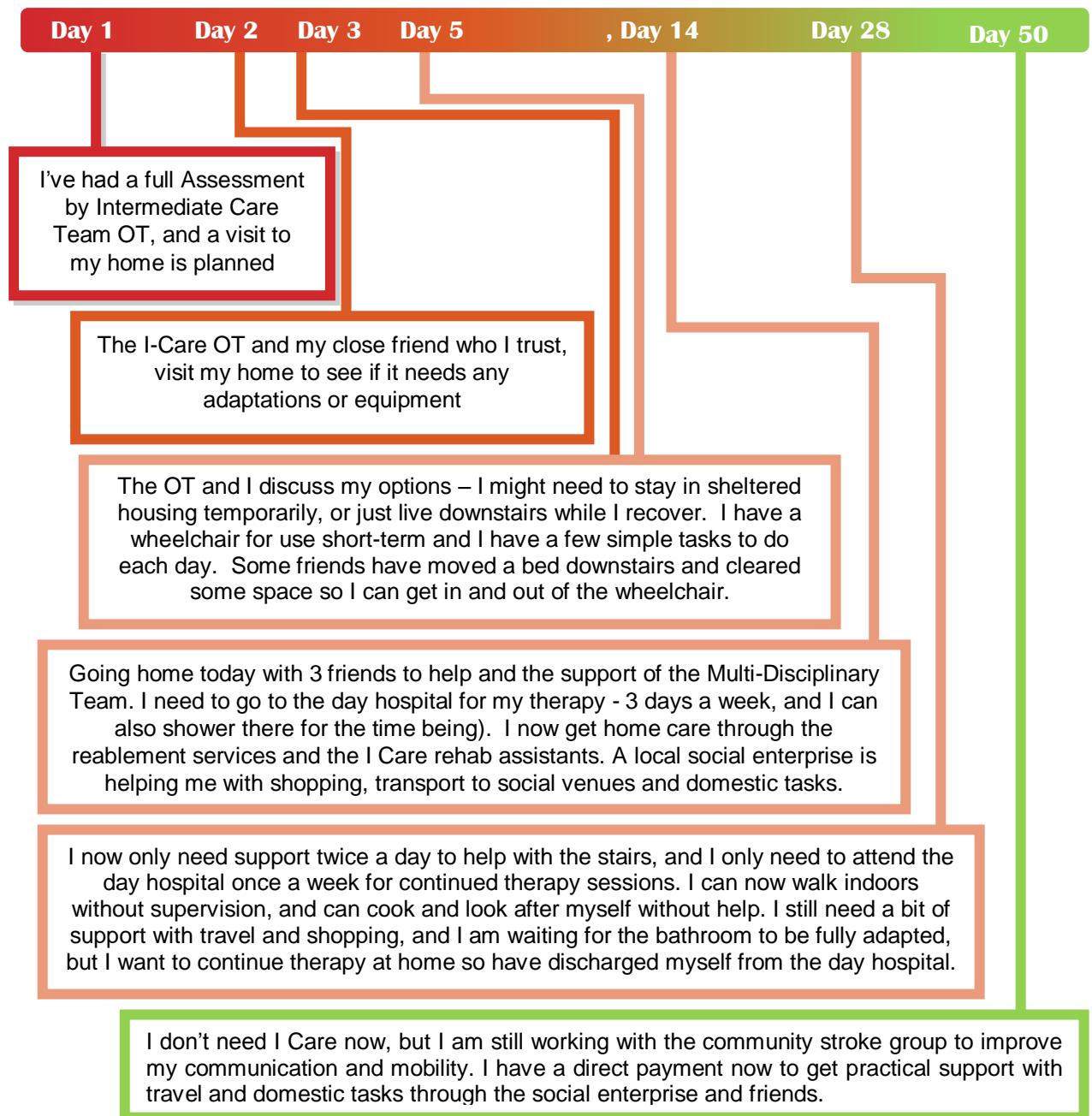
- Rapid assessment by community team carried out to establish whether own home can be used in recovery phase. Alternatives, such as Intermediate Care housing within a sheltered housing unit, or care home should be available if own home is unsuitable.
- Housing and Occupational Therapy teams are fully involved from the outset to ensure any equipment or adaptations required are actioned immediately.

Voluntary Sector contribution

- Links are made with a local voluntary organisation that can provide support and companionship for Eddie when he returns home. Specialising in stroke they are able to help Eddie understand the condition and continue to recover at his own pace at home.

Turn over to read about Eddie's journey.

Time line – How was it for Eddie?



Partnership Example of Good Practice Intermediate Care Hub: Perth & Kinross

Perth & Kinross Intermediate Care Hub provides a single point of access in Perth City, to the community rehabilitation team and discharge services. The team assists in the management of delayed discharges, and can help to facilitate faster discharge and provide prompt access to rehabilitation services. Rapid access older people's assessment is also provided at Simpson's Day Hospital.

Future developments include:

- Intermediate care hubs in North & south localities;
- Build on Intermediate Care beds (step-down) and an Intermediate Care discharge service;
- Outreach Geriatrician/specialist nurse service to support hubs, case management and crisis care;
- Psychiatry of Old Age liaison team
- Early identification of patients with dementia
- SCO support to facilitate early discharge for dementia patients from acute

8. Policy Context

“Our policy goal is **to optimise the independence and wellbeing of older people at home or in a homely setting**. This will involve a substantial shift in focus of care from institutional settings to care at home – because it is what people want and provides better value for money.”

The development of Intermediate Care is one component of the policy described in *Reshaping Care for Older People: A Programme for Change 2001 – 2021*^{xxx}.

This document sets out the Government’s headline ambitions for reshaping care for older people across Scotland, along with the first set of key actions required to deliver our ambitions. It sets out the national framework, within which local partnerships will develop joint strategies and commissioning plans and use the Change Fund as a catalyst to reshape care between 2011 and 2015.

Better integrated approaches through Intermediate Care are central to the priorities of the Reshaping Care programme and the need to ensure improved joint working between local authorities and the NHS and other partners. The Reshaping Care programme promotes an extension of Intermediate Care at home, in care homes and housing settings, to support speedier discharge and faster recovery.

Change Plans have been submitted by all health and social care partnerships in Scotland, detailing how they intend to use the new Change Fund to enhance community services and increase preventative support. The majority of Change Plans include the development of Intermediate Care.

Change Plans

Moray:

Establish a Moray wide multidisciplinary Intermediate Care Team which will provide safe, effective community based assessment/rehabilitation/intermediate care to older people across Moray focusing on the identification of frail elderly who have the greatest risk of admission or re-admission to Hospital or long term care.

Falkirk:

Extend the scope of the current enablement approach to work with service users who are aged 65+ years with long-term conditions and/or are frequent fallers who sustain an injury that does not require hospital admission. In addition, it is recognised that education and training professionals, service users, carers and providers will be crucial to ensure the culture shift required to implement reablement approaches.

The Reshaping Care programme aligns with a number of key national policies:

"It is about making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important."

The *Healthcare Quality Strategy for NHS Scotland*^{xxxā} is a development of *Better Health, Better care*^{xxxā} which builds on the significant achievements already made over the last few years. It aims to deliver safe, effective and person centred care, supporting people to manage their own conditions and making individual outcomes and experience integral to services. The Strategy contains three quality ambitions:

1. Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
2. There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
3. The **most appropriate treatments, interventions, support and services** will be **provided at the right time to everyone who will benefit**, and wasteful or harmful variation will be eradicated.

"Services should strive to support people in managing their own health conditions and remaining independent in their own home rather than being admitted to hospital. Current evidence would indicate that many admissions to hospital or institutional care could be avoided if anticipatory and rehabilitation services were in place."

Co-ordinated, Integrated and Fit for Purpose: The Delivery Framework for Adult Rehabilitation in Scotland, published in February 2007, is a joint document for health and social work. It gives strategic direction and support to all health and social care services and practitioners who deliver rehabilitation or enablement services to individuals and communities. The vision underpinning the framework is the creation of a modern, effective, multi-disciplinary, multi-agency approach to rehabilitation services that are flexible and responsive in meeting the needs of individuals and communities in Scotland.

Re-ablement, recovery and rehabilitation, (the 3Rs) are concepts that are applicable to both older people and those with a long-term condition, across the spectrum of health and social care services. They are integral to the delivery of many of the health and social care policies and work streams, including the Reshaping Care programme, all aimed at enabling individuals to live healthy lives in a homely setting for as long as possible.

A greater emphasis on anticipatory and preventative support in relation to both the carer and cared-for person – which does not have to be complex or expensive – can delay or prevent the need for crisis intervention, and is therefore more cost effective.

Caring Together: The Carers Strategy for Scotland 2010-2015^{xxxiii}

acknowledges the vital contribution carers make to the health and social care system. Included in the actions is the need for training for carers to enable them to remain able to continue in their role. Intermediate Care has the potential to support carers by reducing the number and length of hospital admissions, and providing a range of services which can respond to, or avert, a crisis.

“we also need to do some **new** things, to do some things **differently**, to stop wasteful activity, and to focus on evidence-based activities which yield the maximum benefit.”

Scotland's national dementia strategy^{xxxiv}

The aim of this strategy is to deliver world class dementia care and treatment in Scotland, ensuring that people with dementia and their families are supported in the best way possible to live well with dementia. The Strategy highlights that inappropriate admissions can be reduced by increasing the availability of ‘step-up’ Intermediate Care services that temporarily offer a higher level of care for someone living at home to cope with a short-term need, instead of the person going into hospital.

These publications set out the principles and strategic direction for our future care services: other national

strategies build on these in relation to specific groups or types of need.

“the Intermediate Care Framework will have significant impact on the care provided by community hospitals, especially their links to care homes and home care support.”

Community Hospital Strategy Refresh^{xxxv}

builds on the ‘Developing Community Hospitals: A Strategy for Scotland and reflects on how current strategic priorities should influence the vision for community hospital development. It seeks to demonstrate, through examples of good practice, how community hospitals can become more effective in the delivery of improved pathways of care, especially with regard to supporting the older population. It contains a number of actions for partners that will ‘knit’ community hospitals into the fabric of local care and support services, ensuring improved outcomes for patients.

Age, Home And Community: A Strategy For Housing For Scotland's Older People: 2012 – 2021^{xxxvi}

, published jointly with COSLA in December 2011, sets a clear vision for housing for older people, with the necessary framework for delivery. The strategy is key to supporting a ‘shift in the balance of care’ and reducing the use of institutional care settings, including partnerships with housing providers to deliver intermediate care. It advocates a range of preventative services, which help older people to live independently, safely and comfortably in their own homes; reduce falls and accidents; and support people to return home from hospital, reducing delayed discharge.

9. Links to the delivery framework for adult rehabilitation in Scotland

Published in 2007, this framework made six recommendations:

1. Rehabilitation services should be more accessible and there should be direct access.
2. Rehabilitation services need to be provided locally, with a strong community focus.
3. A systematic approach to delivering rehabilitation to individuals is required, promoting independence, self management and productive activity.
4. Rehabilitation services should be comprehensive and evidence based, should reflect individuals' needs at distinct phases of care, and should identify models to ensure seamless transitions.
5. Practitioners and providers in health and social care services need to be better informed about current evolving roles and expertise within rehabilitation teams.
6. Health and social care professionals need to critically review staff resource deployment through service re-design and skill-mix review.

In addition to these recommendations, individuals, carers and health and social care staff also highlighted the need for strategic co-ordination of rehabilitation services to drive changes across organisational and professional boundaries.

Much progress has been made on implementation of the rehabilitation framework, a number of services have undertaken major redesigns. Some examples include:

- Work is in progress to improve access to and capacity of rehabilitation services by using telerehabilitation and technology within NHS 24. For example in NHS Tayside remote pulmonary rehabilitation has been piloted using video conferencing to deliver an existing programme from a hospital.
- Many Boards are developing a single community assessment and rehabilitation service with a single point of access. An example is NHS Lanarkshire North Partnership, where this is integrated with the local authority and provides direct access to mental health services, reablement and care management.
- Several NHS boards, including Lothian and Fife, now have therapists as part of multidisciplinary accident & emergency teams, helping to prevent hospital admissions .

The Chief Health Professions Officer is developing a Delivery Plan for AHP's that will reinforce the need for integrated health and social care community teams, and will ensure that AHP's are utilising their skills, expertise and leadership to further drive forward this framework. The Delivery Plan will identify how the Allied Health Professions will re-configure their services to accommodate the integrated model of delivery recognising the key contributions from all other health and social care practitioners.

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