Healthcare Improvement Scotland | ihub

Intermediate Care

Atlas Report

July 2018

Improvement Hub

Enabling health and social care improvement

NHS SCOTLAND

Introduction

Chief Officers and their representatives from the 31 Health and Social Care Partnerships were invited to take part in an Intermediate Care and Reablement scoping exercise in early 2017 that comprised an online survey and conversation about Intermediate Care and Reablement within their partnership area. Twenty-five partnerships took part in the scoping exercise; most stated that they are integrated and all provide a reablement approach.

This report sets out the most up-to-date information that we have received on Intermediate Care and Reablement from the partnerships.

This is a live document that can be updated to reflect developments over time. This will allow the partnerships to exchange knowledge on different models of Intermediate Care and identify where support may be obtained.

We ask partnerships to keep the information up to date by using the template here and emailing to hcis.livingwell@nhs.net.

For more information contact Dianne Foster – diannefoster@nhs.net.

Key to service provision table on page 3:

In place

In development

Service provision table

PARTNERSHIP	HOW SERVICES ARE DELIVERED							
	Single point of access?	Intermediate Care at home	Step down beds in care homes	Step down beds in community hospitals	Step up beds in care homes	Step up beds in community hospitals	Hospital at Home	Reablement
Aberdeen City	⚠	✓	✓		✓		⚠	✓
Aberdeenshire	✓	✓	✓					✓
Angus	✓	✓	✓	✓	✓	✓		✓
Borders		⚠	✓	✓	✓	✓		✓
Clackmannanshire & Stirling	⚠	✓	✓	⚠	✓	⚠	✓	✓
Dumfries & Galloway	✓	✓	⚠	⚠	⚠	⚠		✓
Dundee City	✓	✓	✓	✓		⚠		✓
East Ayrshire	✓	✓		✓		✓		✓
Falkirk		✓	✓		✓			✓
Fife	✓	✓	✓			✓	✓	✓
Glasgow City	✓	✓	✓		✓			✓
Highland	✓	✓	✓	✓	✓	✓		✓
Inverclyde	⚠	✓			✓			✓
Midlothian	✓	✓	✓	✓	✓	✓	✓	✓
Moray	✓	✓	✓		✓		✓	✓
North Ayrshire	✓	✓		✓		⚠	⚠	✓
North Lanarkshire	⚠	✓	✓	✓			✓	✓
Orkney	✓	✓			⚠			✓
Perth & Kinross	✓	✓	⚠	✓	✓	✓		✓
Shetland	✓							✓
South Ayrshire	✓	✓					⚠	✓
South Lanarkshire	⚠	✓	✓	✓	✓	✓	✓	✓
West Dunbartonshire	✓	✓	✓		✓			✓
West Lothian	⚠	✓					✓	✓
Western Isles	✓	✓						✓

Information from Health and Social Care Partnerships

Aberdeen City

Service integration with social care	PARTIAL
Aberdeen City is looking to properly integrate it, in its entirety, as they move on in the partnership, but at the moment some parts are integrated and some are stand-alone.	
Description of how services are delivered	
Intermediate Care at home	This is primarily delivered via OT/Physio services. Normal social care (not part of an intermediate care service) is provided, then an occupational therapist or physio steps in to provide the therapeutic element.
Step down beds in care homes	They currently have 20 beds in Rosewell House Care Home. OT/Physio staff have time factored into their roles to provide the therapeutic elements, along with wrap-around social care. There are also 10-15 flat properties, which have Social Care staff and AHPs who provide therapeutic input. There is a flexible service (intermediate care and rehabilitation and delayed discharge for interim placement). Minimum of 10 at any one time but can accommodate up to 15 patients.
Community hospitals	There are no community hospitals.
Step up beds in care homes	This is the same as service provided for step down beds in care homes (above). Rosewell House Care Home and the flat properties take patients from hospitals (step down) and input directly from the community to prevent hospital admission (step up).
Hospital at Home	This is not live at the moment (currently in active development) - in the scoping/planning/test of change stage at present. It is a priority area for the partnership.
Reablement services	
Service description	Reablement is very much linked into intermediate care. Work is done in same setting as intermediate care.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	They will pick up other community care services (e.g. mental health services. This is not what the service is designed for, but it is flexible enough to allow it when it works).
Others in receipt of supported living	Yes (this is a very rare occurrence).
Do you have a single point of access for these services?	No. They recognise that this is desirable, and are currently working towards this aim.

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Aberdeenshire

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	Virtual Community Wards (VCW) are in place aligned to GP practices. The larger practices operate a morning huddle every day, the smaller practices less frequently. The initial results evidence a significant reduction in hospital admissions. Patients may be admitted to the VCW to prevent admission.
Step down beds in care homes	They have two care homes providing intermediate care beds, two in one site, and one in the other. The multidisciplinary team supports these beds.
Reablement services	
Service description	The enablement pathway and paper work has presently been simplified. They attempted to align it with self-directed support paperwork but have returned to simpler goal-setting paperwork. Enablement is set to be the default when care is requested and they are presently looking at how we increase the numbers on the enablement pathway
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	They are presently looking at access points into services.
Do you use technology-enabled care?	Yes

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Angus

Service integration with social care YES

Early Supported Discharge/Prevention of Admission (ESD/PoA) has always been a joint Health and Social Care service. Independent intermediate care the beds are accessed by the discharge co-ordinators in Ninewells and weekly reviews are carried out by a Social Care member of staff. The beds are purchased by Social Work but Health provides the OT, physio, MFE and GP elements.

Reablement is social care only but well-known to health colleagues who understand the aim of the reablement service.

Description of how services are delivered

Intermediate Care at home	This is provided by ESD/PoA teams. Referrals from hospitals for ESD are made by discharge coordinators (Ninewells) or link nurses in the community hospitals. Referrals are made on the Multidisciplinary Information System (MiDIS) to the Angus coordinators who arrange the social care input. Referrals may also be made to OT, physio and district nursing at the same time. The team, although not co-located, works very closely together to coordinate their input and deliver a focused rehabilitation service where the support is reviewed and adjusted on a regular basis and where the aim is always to maximise independence. For Prevention of Admission, referrals are made by GP or district nurse to the Angus coordinators and thereafter the same process is followed. Early Supported Discharge and Prevention of Admission services are provided for periods of up to four weeks.
Step down beds in care homes	There are six beds commissioned in an Angus care home for this purpose. They are accessed by the Angus Discharge Coordinators based in Ninewells Hospital. As stated previously OT, physio and GP input is provided and weekly reviews are chaired by the Senior ESD/PoA Coordinator. The service is available for up to six weeks with the aim to discharge to home with ESD input or longer-term service if required.
Step down beds in community hospitals	The beds in community hospitals are used for step down from acute settings for continuation of assessment, treatments and rehabilitation.
Step up beds in care homes	Three beds in one locality from 4th April 2018.
Step up beds in community hospitals	Admission to community hospital beds from home is for a period of assessment, appropriate treatment and rehabilitation, where this cannot be provided in the person's own home or care home.
Hospital at Home	They do not operate a hospital at home service.

Reablement services

Service description	There is an enablement and response team in each locality providing an enablement approach for up to four weeks at home with access to occupational therapy and physiotherapy.

Reablement service provision

Care at home	This is the primary focus of the enablement teams.
Hospital discharge	This is provided where the individual does not meet the criteria for early supported discharge.
Others receiving community care services	In the main, the focus is on older people and people with a physical disability, but service users from any client group requiring care at home could access the service.
Others in receipt of supported living	They could be considered, but there may be other more relevant services they could access e.g. in Mental Health or Learning Disability Services.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	For Intermediate Care Services the Angus Coordinators are the single point of contact and referrals can be made 7 days per week 8am – 9pm There is one point of access in each locality
Do you use technology-enabled care?	A range of equipment provided following assessment by the response service or from the care and repair service.

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Borders

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	This is only delivered in one locality by the Cheviot team.
Step down beds in care homes	There are AHPs on site, and carers on site. GP and district nurses as required.
Step down beds in community hospitals	There are on-site staff.
Step up beds in care homes	There are AHPs on site, and carers on site. GP and district nurses as required.
Step up beds in community hospitals	There are on-site staff.
Hospital at Home	N/A
Reablement services	
Service description	As above (this can be discussed further with SB Carers Lynn Crombie & Murray Lees S/W)
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	Yes
Do you have a single point of access for these services?	No

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Clackmannanshire & Stirling

Service integration with social care Not Full

It is part of the strategic plan with the HSCP. AHPs work alongside social care.

Description of how services are delivered

Intermediate Care at home	The Partnership has developed an Enhanced Care Team consisting of a team of community nursing and AHP professionals, supported by GP fellows, who can provide appropriate care and support which offers an alternative to hospital admission, or short-term support (up to 7 days) following discharge from hospital. This team are able to make direct referral to Community Reablement Teams and Technology-Enabled Care, and users of this service are offered the opportunity to complete an Anticipatory Care Plan where this is appropriate.
Step down beds in care homes	Short stay assessment bed provision within care home settings across the HSCP. There is a pathway to support effective discharge from acute settings to step down bed provision
Step down beds in community hospitals	Not at the moment. Community hospital models in the Partnership under review in readiness for Stirling Care Village. Evaluation of this model will inform role of community hospital across HSCP.
Step up beds in care homes	Short stay assessment bed provision within care home settings across the HSCP. Pathway in place to support step up from community as avoidance of unnecessary hospital admission or where service user would benefit from care and assessment over 24 hours.
Step up beds in community hospitals	Not at the moment. Community hospital models in the partnership under review in readiness for Stirling Care Village. Evaluation of this model will inform role of community hospital across HSCP.
Hospital at Home	Enhanced Community Team function to support alternative to hospital admission and work to well established pathways to support unwell adults and uninjured fallers. This service is supported via GP fellows, but is not a fully developed hospital at home team. The work of this service will link to Frailty Pathways currently in development.

Reablement services

Service description	The HSCP currently operates a social care model of reablement consisting of a multi-disciplinary social care team. The team consists of front line carers, co-ordinators and occupational therapy support, with referral pathways for additional AHP input where necessary.

Reablement service provision

Care at home	Yes
Hospital discharge	Yes, this is the main referral route.

Others receiving community care services	Yes, for all adult care groups.
Others in receipt of supported living	Yes
Do you have a single point of access for these services?	This is currently in development as a Strategic Plan Priority for the HSCP. In supporting effective discharge from hospital, intermediate care services liaise with a single point, the Discharge Hub. Meanwhile, partners are working towards re-design of internal teams and processes to allow for greater opportunity to align to a single point of access
Do you use technology-enabled care?	The HSCP views TEC as an enabler for service users, and offers assessment utilising a range of technology during individual assessments. The range of TEC considered includes community alarm, additional peripheral passive monitoring, GPS technologies, digital solutions and assessment tools which monitor lifestyle. The partnership is about to launch home and mobile health monitoring system Florence as part of its approach to primary care transformation.

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Dumfries & Galloway

We do not currently have any further information on these services.

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Dundee City

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	There is a range of facilities.
Step down beds in care homes	There is rehab and assessment, and have commissioned the Bluebell unit, which has 20-25 beds. Currently developing step down pathway for the Mackinnon Centre.
Step down beds in community hospitals	Yes, five assessment beds.
Step up beds in community hospitals	This is at a very early stage.
Other Services	Step down housing – fully furnished, part of the assessment service.
Reablement	
Service description	Enablement services – social care is delivered by partnership, and anyone out of hospital requiring enablement.
Reablement service provision	
Care at home	All adults
Hospital discharge	All adults
Others receiving community care services	All adults
Others in receipt of supported living	All adults Mental health services – step down is available for adults with children.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes Hospital – yes, there is an integrated discharge hub, for non-hospital – there is the local authority contact team which needs reviewed. Community nursing – yes Intermediate Care - yes

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East Ayrshire

Service integration with social care YES

Comments: Intermediate care is integrated for the past five years, with both health and social care staff on the team.

This incorporates both health and social care staff within the Intermediate Care Team (ICT) East and effective links with Locality Services, District Nursing Teams, Community Hospitals and independent sector providers.

Enables a multi-disciplinary approach to, not only provision of care but regular reviews and follow up to ensure the right support is provided at the right time by the right person.

Description of how services are delivered

Intermediate Care at home	Assessment is carried out either at home or on hospital ward. Services can include home care support if required. Service users are seen in their own home and comprehensive assessment is carried out, either following discharge from hospital or to prevent admission. Discipline-specific staff will visit dependent on individuals' needs to complete an assessment and personalised care plan with the service user. All service users are encouraged to set goals and relevant staff work with them for a defined period of time to achieve these goals. An exit questionnaire is completed following completion of the plan to determine to what extent the goals have been achieved and identify any longer term support that may be required from community based services such as District Nurses, Care at Home, and Care Management teams.
Step down beds in care homes	This facility is no longer part of the service, however East Ayrshire operates a Discharge to Assess process, whereby an individual with complex needs but who does not require an Acute Hospital bed and has limited or no rehab potential may be discharged to a care home to enable a full assessment of their longer-term care needs in a homely environment. This enables a more comprehensive assessment of their needs and ensures a multi-disciplinary and planned approach to their care.
Step down beds in community hospitals	East Ayrshire has access to two Community Hospitals for step down support and the ICT East works closely with these wards to ensure a seamless approach to their discharge home and ongoing provision of care in their own homes. ICT East has a dedicated team of staff based at one of the Community Hospitals and this has supported excellent communication links and speedy assessment and care planning. ICT East also has staff based within the Acute Hospital as part of a "duty" service who assess and co-ordinate early discharges. East Ayrshire also has a Hospital Social Work team who are an integral part of supporting early discharges alongside ICT East particularly where there may also be complex social needs.
Step up beds in care homes	This facility is no longer part of our service, however East Ayrshire is currently running a pilot programme to support a palliative care bed in an independent care home as an alternative to admission to Acute Hospital or long term care provision.

Step up beds in community hospitals	East Ayrshire has access to two Community Hospitals for step up support and ICT East works closely with these wards to ensure a seamless approach to their discharge home and ongoing provision of care in their own homes. ICT East has a dedicated team of staff based at one of the Community Hospitals and this has supported excellent communication links and speedy assessment and care planning. ICT East representatives attend Locality Hub meetings and GP liaison meetings on a weekly basis and this supports the early identification of individuals who may benefit from step up support and enables multi-disciplinary care planning and decision making.
Hospital at Home	This is not a model that is currently used within East Ayrshire HSCP, however the ICT service is currently undergoing a review and redesign process that is likely to include elements of this model moving forward.
Reablement services	
Service description	A multi-disciplinary/inter-disciplinary team of professional clinicians and support staff who work generically to provide an alternative to hospital admission or support discharge from a hospital setting. It is community-based, but with a duty worker element within a main acute hospital. The service is able to respond on the day of referral, with access to support which includes –comprehensive assessment, rehab and enablement focussed care plan, adapted equipment (as required), home care support, access to smart supports, referral to financial inclusion as well as access/referral to other services within the community. The ongoing review element of the care plan is an essential element to ensure enablement is achievable and successful. Whilst ICT East is noted within the East Ayrshire Partnership structure as an individual team, its success is wholly reliant upon its ability to work alongside the whole range of community based-services and acts as the bridge between acute services and community services to ensure an individual receives the right support at the right time from the right person.
Reablement service provision	
	Reablement services are provided for care at home, hospital discharge, others receiving community care services, and others in receipt of supported living. Referrals are received from a wide range of professionals and ICT East will often step in to an established care at home service provision where a deterioration is identified for those with long term conditions. ICT East will in these circumstances work alongside the existing Care at Home team to devise and implement a rehab and enablement care plan and ensure appropriate review and follow up is completed. The Locality Hub meeting and GP Liaison meeting provide an essential opportunity to identify individuals who may not be in receipt of formal services but are known to GPs and are at risk of hospital admission or break down in their current care arrangements. ICT East is able to step in for a defined period of time to provide reablement support and often prevent the need for ongoing and longer term formal support provision. Where

	ongoing support is required it is often at a reduced level than that which would have been required had ICT East not been involved. District Nurses also attend these meetings and are able to request additional support for an individual known to them who may be experiencing a short-term deterioration. Similarly following ICT East intervention, District Nurses may provide follow up support.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes There is one number to access the service and domiciliary physiotherapy and community occupational therapy (Health). It is also the single point of contact for Scottish Ambulance referrals in East Ayrshire to facilitate people staying at home rather than being conveyed to hospital.

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Falkirk

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	Care home, bed based, accommodation based with supported housing.
Step down beds in care homes	The majority of Summerford House referrals are for step down intermediate care referred through the Discharge Co-ordinators at the Discharge Hub.
Step down beds in community hospitals	Falkirk Community Hospital is not designed as intermediate care.
Hospital at Home	This is an area that Summerford House have begun to explore with the enhanced nursing team to see if it was a service we could offer people with support from the enhanced nursing team, the G.P Fellows and our AHP colleagues. It may be that the service could meet the criteria to be able to offer reablement support whilst someone was to receive intravenous antibiotics or other treatment that would not necessarily require an acute hospital admission. There would be a lot of work to ensure that Summerford are able to perform this role safely and to ensure that they are an appropriate service to perform this function.
Reablement services	
Service description	Summerford House contains ten intermediate care beds, which will rise in a staged manner to 20 following refurbishment work around April 2018**.** They support both step up and step down and have begun to have discussions with the Enhanced Nursing Team regarding building and developing a robust step up program. Their intermediate care service works in partnership with our colleagues from Reach which include occupational therapists and physiotherapists. They work with people to regain skills they may have lost and return to their base level of functioning to return to living at home as independently as possible. Whilst this work is ongoing they ensure adaptions to the individuals' property are in place to support a safe return home and make applications for appropriate packages of care. As medication administration methods can be a barrier to overcome in sourcing packages of care they work with individuals to be as independent as possible with the administration of their own medication. They work towards discharge in 6-8 weeks, but this has at times been extended due to housing issues, lack of care packages or individuals becoming unwell and requiring further hospital admission.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	A shift is needed
Others in receipt of supported living	Yes

Do you have a single point of access for these services?	All hospital based referrals to Summerford House come through the Discharge Hub but to be able to respond quickly to step up referrals they need to be able to accept referrals directly from their community-based colleagues. A multidisciplinary team met regularly to discuss streamlining the pathway and this work is ongoing.
Do you use technology-enabled care?	Yes

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Fife

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	START Model This project is designed to support the 72-hour discharge target by enabling people who require a care package to return home from hospital as quickly and as safely as possible with a care at home service which is tailored to their needs. Evidence has shown that people leaving hospital initially require significant input, but once home and stabilised this is often no longer required and the package of care can be reduced. The project aims to ensure that people's needs are reviewed following the six week initial programme of care so that those who require it continue to be supported at home with either in-house provision or an external agency.
Step down beds in care homes	Assessment Units This is a new concept which supports people to leave hospital and finalise their assessment within a care facility. Funding for this new model supports the delayed discharge target of 72 hours. The partnership has successfully implemented the model in Kirkcaldy, with eight beds now on stream. Discussion is underway in other areas to ensure full roll out. The target for facilities is 40 beds.
Step up beds in care homes	STAR MODEL. This model is delivered jointly between Fife Health and Social Care Partnership and external care home providers. The service gives the encouragement, support, skills and independence needed for people to return to/stay in their own home by offering tailored support in a care home for a short period of time. These Intermediate care units enable patients to be discharged to a registered care home from hospital, or admitted into an intermediate care placement to prevent admission to hospital as part of a journey of returning to their own home and community. Once admitted to the registered care resource intermediate care services can help to facilitate the return of an older person to their own home using a reablement approach. This model was first implemented within Alan McLure Care Home in Glenrothes and evidence has shown that this has been a model which has supported people to return home with support following a period of care.
Hospital at Home	Fife operates hospital@home provision.
Reablement services	
Service description	Fife Health and Social Care Partnership aims to support people to live at home independently, safely and for as long as possible. Home carers can help with personal care and basic practical tasks around the home. The service is provided by carers who are either employed directly by Fife Council or by a partner agency.

Reablement service provision	
Care at home	As above
Hospital discharge	As above
Others receiving community care services	There are plans to develop this area
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes - We have a single point for social care and a single point for health, which work well but we recognise that we need to bring this into one point of contact for all services, if that is possible, further work is required to identify the possibilities.

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Glasgow City

Service integration with social care YES

Comments: As much as possible. There is a steering group with health and social care. Reablement clinicians set complex and non-complex goals and packages of care.
Cordia have their own OTs. There are multi-disciplinary rehab teams including for example mental health services and dieticians.

Description of how services are delivered

Intermediate Care at home	This is predominately a reablement service, but it links with Intermediate Care. Cordia provides the homecare (reablement) support. There are community rehab teams which respond in an hour and can order home care directly. Four-hour response to A&E referrals.
Step down beds in care homes	Out to tender for 15 beds within six care homes across Glasgow City (2-4 year contract). There is a limit of two admissions and discharges per day. Glasgow will stagger payment for beds, but providers traditionally want all the money upfront. Length of stay is slightly higher than expected but the partnership is OK with this as if there is still rehab potential for a person then it is better to give them time, rather than send them home with home care. Red Cross transfer people from IC to their home. People are allowed a trial period at home before officially giving up their IC bed. This enables the person to see if they are actually able to remain at home without support. One of the care homes has two flats which are used to check if someone is able to carry out everyday tasks. NHS Continuing care beds will also become intermediate care, complex and palliative care beds.
Step down beds in community hospitals	Glasgow doesn't have community hospitals.
Step up beds in care homes	Consultants involved in 6-7 bed step up facility in the north east. GPs do a 24-hour review there is also a weekly review by a geriatrician. The average length of stay is ten days.
Hospital at Home	Might look at this in future but do not have a traditional hospital at home service now. Glasgow City does have things like Fast Track palliative care service though. Home is Best – Cordia have close links with housing and telehealth.

Reablement services

Service description	Reablement services are delivered by Cordia, who also deliver 96% of home care in Glasgow City. Therefore everyone is given opportunity for reablement as part of their home care package. The contract with Cordia has been changed to let them do more of the assessments. TUPE'd staff over to enable this to happen.

Reablement service provision	
Care at home	Yes
Home discharge	Yes
Others receiving community care services	Yes
Others in receipt of supported living	Yes, i.e. Adult services. Mental health problems, physical disabilities. Although of approx 5,500 clients approx 5,000 would be over-65.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes. Hospital Line – discharges from all hospitals go through this line. Call handler service – social care direct.

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Highland

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	In Inner Moray Firth, there is a reablement service delivered through Care at Home. In North and West which is more remote and rural, enablement is embedded in the integrated community teams.
Step down beds in care homes	Care is provided by Care Home staff overseen by Community Integrated Teams and supported by the relevant Lead Professional
Step down beds in community hospitals	All of the community hospitals provide this service to assist with flow in the acute hospital.
Step up beds in care homes	All of the in-house care homes work to prevent escalation of care leading to admission to hospital. We offer support to independent providers as requested
Step up beds in community hospitals	As above
Hospital at Home	This service is nor currently provided, but Highland have aspirations to provide it.
Reablement services	
Service description	In Inner Moray Firth Operational Unit (IMFOU) that is in South and Mid Highland, there is a separate reablement service delivered through Care at Home and supported by Lead Professionals. Referrals are taken from hospital and community teams and intensive support is provided for a period normally up to 6 weeks In North and West, additional health and care support workers have been recruited to integrated community teams who have the responsibility of providing enablement level of care with enablement being the default position until people have been assessed in their home setting.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	Yes
Others in receipt of supported living	Yes
Do you have a single point of access for these services?	Yes - All contact with the teams can come through a single number which is manned by a Health and Social Care Coordinator

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Inverclyde

Service integration with social care	YES
Comments: It works well with homecare.	
Description of how services are delivered	
Intermediate Care at home	Reablement response team – there is a homecare structure with AHPs allocated specifically, and enhanced AHP services. This creates flow from step down beds. The intermediate care service works closely with homecare to set goals and work with staff to monitor these.
Step down beds in care homes	No
Step down beds in community hospitals	No
Step up beds in care homes	These are available across the district. The care home closest to the person's own home is approached, and their own GP care manages. There is a maximum of six beds across care homes and the Inverclyde Community Rehabilitation team supports them.
Other Services	Fast Track service – specialist outreach nurse and registrar at day hospital. Closely working with district nursing service.
Reablement services	
Service description	Includes Home from hospital, Rapid response, Enhanced role, New allocation of work or review. The service includes: Home from hospital, Rapid response, Enhanced role, New allocation of work or review. Stage 1 – Initial Assessment Stage 2 – Set Goals Stage 3 – Weekly meetings with the team regarding progress Stage 4 – Staff continue with rehabilitation Stage 5 – Week 4 – goes to approval panel for funding longer term as required Own equipment stores for hospital discharge equipment and rapid response. Core Community Nursing support. Support complex care management.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	Yes
Others in receipt of supported living	Yes for assessment that long term needs are being met.

	60:40 ratio SOCIAL WORK: Private provision. Except end of life or dementia, where a change of staff may be detrimental to the care of the individual person.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	In development - Developing at this stage. Social Work & Homecare, OT and Inverclyde Community Rehabilitation team Yes: For reablement and response.

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Midlothian

Service integration with social care	YES
Comments:	
Description of how services are delivered	
Step down beds in care homes	40-bedded Highbank Care Home and seven beds at Newbyres Village Care Home.
Hospital at Home	Maximum 15 patients

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Moray

Service integration with social care NOT FULL Comments: Moray has started to integrate the service (going through a time of change), and is looking at what the reablement service needs to be going forward. It is not currently at the level it should be.	
Description of how services are delivered	
Intermediate care at home	7-day working for allied health professionals Occupational therapist located in the emergency department within the acute hospital prevent unnecessary admission Jubilee Cottages providing high-intensity rehab and assessment facility. Health support workers working in and out of hours to support discharge and prevent admission. Home care providing reablement at home. Access team providing rapid assessment and service delivery.
Step down beds in community hospitals	Five community hospitals at the moment (rural areas). Looking at the future of these hospitals.
Other services	Moray have health beds with in one of the very sheltered complexes which provides an alternative to traditional hospital admission. The staff group also can provide medical support where appropriate within patients' homes.
Reablement services	
Service description	There is a team of home carers and health support workers who provide a reablement service across Moray.
Do you have a single point of access for these services?	Moray have an access team that deals with all new service users requiring health and social care services and support.
Do you use technology-enabled care?	Yes

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North Ayrshire

Service integration with social care Hospital Social Work Team.	YES
Description of how services are delivered	
Intermediate Care at home	North Ayrshire Intermediate Care Team is accessed via an Intermediate Care and Rehabilitation Hub.
Step down beds in care homes	They have had previous models and are currently in consultation with care sector.
Step down beds in community hospitals	These are predominantly in Woodland View ward. Central Ayrshire has 30 beds.
Step up beds in care homes	They have had previous models and are currently in consultation with care sector.
Step up beds in community hospitals	Most of the bed capacity is taken up with step down, ability to step up in development
Hospital at Home	They have enhanced their Intermediate care at home by adding a GP and an advanced nurse practitioner.
Other Services	SAS Pathway Falls & Frailty, Telehealth for COPD Feb/March, Community Ward
Reablement services	
Service description	We have an occupational therapist, reablement carer-led service, as well as the above services.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	They have a hub in place for hospital and community referrals. This is currently Monday to Friday with limited out-of-hours access through Ayrshire Doctors On Call. They are awaiting a decision on the business case for 7 day working.
Do you use technology-enabled care?	They currently have a COPD telehealth care monitoring, and are planning to extend this.

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North Lanarkshire

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	The Community Assessment and Rehabilitation Service (CARS) Rehabilitation teams provide this. Planned development: in February 2017 there will be a staff hub looking at intermediate care in the person's own house, rather than taking them to a unit.
Step down beds in care homes	Two social work units, Monklands and Muirpark, managed via social work services. 28 beds.
Step down beds in community hospitals	Wester Moffat and Coathill Hospitals. There is particular focus on these with CARS attending multidisciplinary team (MDT) meetings on a weekly basis to agree a timescale for supporting discharge.
Hospital at Home	Lanarkshire-wide Hospital @ Home service.
Reablement services	
Service description	Everyone goes through the new service and then passes to mainstream after 12-14 weeks. There are link workers to help with activities to reduce social isolation and increase confidence.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes – planned discharge
Others receiving community care services	Yes
Others in receipt of supported living	This is up for tender
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes, this is in development through locality modelling. 3 seniors in reception and they will be point of contact.

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Orkney

Service integration with social care	YES
Description of how services are delivered	
Intermediate Care at home	The service is fully operational from 0800-0830 7 days per week on the Orkney Mainland, however there is not a service on the non-linked islands.
Step down beds in care homes	This has been piloted in 2017/18, however bed usage has been low.
Step up beds in care homes	No
Hospital at Home	No
Other services	There is a mobile responder team who can provide support for up to three days to support someone to remain at home or be discharged from hospital earlier.
Reablement services	
Service description	Reablement is a core function of the intermediate care and homecare teams.
Reablement service provision	
Care at home	There is a reablement approach, and all staff have had the training.
Hospital discharge	Yes
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes, for adult services through a social worker 9-5 on weekdays.
Do you use technology-enabled care?	There is a wide range of equipment available which can meet the many differing support needs of people who may be at risk of accident or injury in their own homes.

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Perth & Kinross

Service integration with social care
YES – although aligned H&SC management arrangements

Description of how services are delivered

Intermediate Care at home	Recently developed Home Assessment & Recovery Team (HART) providing reablement in-house and co-ordinating transition to mainstream (private provision) Care at Home Services. This service is intrinsically linked with the Hospital Discharge Hub and Hospital Discharge Team. Each Perth & Kinross Locality is developing at pace Integrated Care Teams (ICTs) which are multidisciplinary (Health & Social Care) and who will jointly co-ordinate and provide rehabilitation and care within the person's own home. This supports early and timely supported discharge from a hospital setting. The ICTs also provide opportunities for early prevention and intervention avoiding admission to hospital where possible
Step down beds in care homes	There is no formal step down model for Care Homes although their care homes are used for the purposes of interim placements when Care at Home not available. They recognise that this is not ideal, nor fully person-centred, therefore they are currently exploring intermediate care bed provision within a care home setting – particularly Perth City.
Step down beds in community hospitals	They have dedicated step down beds in each of their four Community Hospitals – Blairgowrie, Auchterarder, Crieff and Pitlochry. Admission is co-ordinated by the Hospital Discharge Team from Perth Royal Infirmary and Ninewells Hospital. They are currently remodelling their medicine for the elderly services, which will incorporate a refresh of their current community hospital model – this is ongoing as part of the NHST Tayside emerging Integrated Clinical Strategy. They step down frail elderly patients within Perth Royal Infirmary to Tay Ward (Medicine for the Elderly) where they receive intensive rehabilitation before discharge home or to long term care.
Step up beds in care homes	There is a process in place within Perth & Kinross across health and social care to step up people from the community into a care home for short term rehabilitation interventions. These people are currently reviewed through the locality ICT meetings weekly to prevent escalation or deterioration.
Step up beds in community hospitals	Currently GPs across Perth & Kinross can directly admit into any community hospital for short term rehabilitation and/or medical/nursing review. We also provide step up end of life care. This is not the case however for Tay Ward where referrals come through the PRI system.
Hospital at Home	In Perth & Kinross we have dedicated care Home Liaison particularly for those living with Dementia. This is preventing admission to acute Psychiatry of Old Age Wards.

Other services	Post-diagnostic support pathway delivery and frailty/deteriorating person pathway delivery is preventing unnecessary admission into an acute setting or creating earlier intervention thus preventing admission. Each Perth & Kinross locality is developing at pace Integrated Care Teams (ICTs) which are multidisciplinary (Health & Social Care) and who will jointly co-ordinate and provide rehabilitation and care within the person's own home. This supports early and timely supported discharge from a hospital setting. The ICTs also provide opportunities for early prevention and intervention avoiding admission to hospital where possible Perth & Kinross have developed a Psychiatry of Old Age Liaison Service, which is supporting transition from hospital to home. This service also provides support to community hospitals in terms of dementia and delirium care. The Partnership has created an integrated Front Door Frailty Assessment Team in Perth Royal Infirmary – this includes a multi-professional team (inclusive of social care) and lead by the geriatricians. This prevent unnecessary admission to hospital and is improving person centred quality of care by detecting frailty and delirium early. P&K also have developed a comprehensive geriatric assessment service based in Perth Royal Infirmary. We also provide rapid access to assessment for local GPs within this service. It is planned to roll out the comprehensive geriatric assessment service model across all Perth & Kinross localities – led by geriatricians and advanced nurse practitioners.
Reablement services	
Service description	Recently developed Home Assessment & Recovery Team (HART) providing reablement in-house and co-ordinating transition to mainstream (private provision) care at home services. This service is intrinsically linked with the Hospital Discharge Hub and Hospital Discharge Team.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	Yes
Others in receipt of supported living	Yes

Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes – There is an early intervention service, and a dedicated telephone number and a single point of access – up to 12 weeks.
Do you use technology-enabled care?	P&K provide community alarm units with fire and flood sensors. We can also provide TEC equipment to monitor people's activity at home following hospital discharge.

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Shetland

Service integration with social care	YES
Reablement services	
Service description	OTs and physios work with social care workers to formulate reablement plans and put them into action.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Other receiving community care services	Yes
Others in receipt of supported living	They would be eligible to receive support but little is provided at present.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes - Referrals to Team Leader. Referrals to central admin point in team.

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South Ayrshire

Service integration with social care	YES
Comments: The service has been integrated for five to six years.	
Description of how services are delivered	
Intermediate Care at home	The community ward and rehab teams are integrated. This is evolving more slowly with community rehab at Biggart Hospital. The AHP lead for rehabilitation is reshaping around the day hospital. 20-bed Girvan hospital. Redesign of Biggart from sub-acute to rehab including palliative care.
Step down beds in care homes	No - staffing crisis due to overspend means no recruitment of nurses.
Step down beds in community hospitals	No
Hospital at Home	Developing Ayrshire-wide model based on Lanarkshire but need resource. Emergency care at home and in reach for frail older people (linked to ACPS)
Reablement services	
Service description	Homecare has been taken out of Intermediate Care and Enablement Services (ICES) and co-located to reablement hub. There is intensive support homecare with AHP input short-term. The service includes telecare.
Reablement service provision	
Care at home	Yes
Hospital discharge	Yes
Others receiving community care services	No, there is short-term input only.
Others in receipt of supported living	No, this is dealt with via mainstream and area team.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes - ICES linked to community based rehab. Rapid response white board meeting. Single point on same day.

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South Lanarkshire

Service integration with social care YES

There are multidisciplinary teams, integrated community support teams and hospital at home. Step up/down has been developed around the integrated support team.

Description of how services are delivered

Intermediate Care at home	Localities are considering this approach as a future development in services in order to facilitate discharges from hospital and maximising independence following hospital admissions.
Step down beds in care homes	The Partnership is continuing to develop and expand intermediate care within care homes. An evaluation of three intermediate care facilities has demonstrated the contribution intermediate care is making to supporting people to return to their own homes following time in hospital. Care homes provide either individual apartments or individual sleeping and bathroom facilities. IC support is no more than the optimal level of home care a person could expect if they were back in the community. Staff endeavour not to provide support outside of the agreed visits and encourage people to do as much for themselves as they are capable of. IC can also identify risks/support needs that families were previously unaware of. Referrals come from social workers, with screening and further information-gathering by the care home manager and Occupational Therapist (OT). This multi-professional 'hub' approach has created expertise in person-centred dependency assessments that also maximise bed occupancy.
Step down beds in community hospitals	Intermediate care is provided within community hospitals in South Lanarkshire. Over the past year South Lanarkshire HSCP have begun the evaluation and implementation of Intermediate Care interventions within hospital settings. This builds on the development of integrated Health, AHP and Social Work teams and redesign and improvement of physiotherapy services resulting in greater skill mix, allowing more effective focus across community and offsite beds. Recent improvement work has focused patients, carers, volunteers and staff to work together towards the same goals for the patient which will allow them to return home.
Step up beds in care homes	Step up services are available within some community hospitals. These provide IC and rehabilitation for people. Services provide an alternative to acute hospital admission and provide safe care and assessment for the individual to avoid hospital admission and support the person to maximise their independence.
Hospital at Home	The Hospital@Home service supports three of the four localities across South Lanarkshire. The service comprises nursing, physiotherapy, occupational therapy and mental health nursing support. The teams are consultant led with nursing and AHP staff

	MINTS trained. The aim of the service is to provide an alternative to hospital admissions for those who meet the criteria for the service. Roughly 80% of people referred to the service are supported at home.
Reablement services	
Service description	The aim of South Lanarkshire home based reablement service, Supporting Your Independence (SYI), is to increase capacity and ensure older people's independence is maximised to enable them to remain at home. People are provided with a maximum six weeks of reablement, after which time many require no further service or reduced service.
Reablement service provision	
Care at home	Yes
Home discharge	Yes
Others receiving community care services	Self care, self management, less formally, mental health
Others in receipt of supported living	Supported living for 48 users. Reablement, supporting, upskilling
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Individual services have a single point of contact but there is currently no overarching single point of access. As Partnerships continue to develop and embed integrated services and working this may be something which will support people through pathways.
Do you use technology-enabled care?	A technology-enabled care programme has been in place for a number of years. This has developed a variety of TEC solutions services which support those with conditions including hypertension, Stress control, and dietetics. Recently the TEC team were winners of the Digital Health and Care team award. The team have established, and are rolling out, video conferencing in care homes. One of the aims is for health and social care staff to give additional advice on individual residents. Another aim is to act as an alternative for residents attending clinic appointments.

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West Dunbartonshire

Service integration with social care YES It became integrated in 2015.	
Description of how services are delivered	
Intermediate Care at home	9-5 service OOH Adults/Older People Integrated nursing service
Step down beds in care homes	They have community nurse led beds which can be accessed by health and social care teams, as well as out of hours services, including GPs.
Step down beds in community hospitals	There is no community hospital.
Step up beds in care homes	They have step down based within sheltered housing, as well as respite beds within care homes in the HSCP and independent sector services.
Step up beds in community hospitals	There is no community hospital.
Hospital at Home	No, tends to be community service.
Other services	They have community nurse-led beds, which can be accessed by health and social care teams, as well as out-of-hours services, including GPs, as well as integrated community health and care services within the community.
Reablement services	
Service description	It is based within Care @ Home, not very familiar with it.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes - 1 call. Qualified social workers, district nurses, and OTs will take the call and move the person on to the appropriate service.
Do you use technology-enabled care?	This would not be specific to intermediate care, as this service covers all individuals. TEC has been a cornerstone to their care at home service for some time. They have also received additional monies to focus on chronic obstructive pulmonary disease (COPD), focusing on non-attenders and hospital discharge planning with TEC to support discharge outcomes.

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West Lothian

Service integration with social care	YES
West Lothian consider their services amongst the most integrated in the country. But it is still a journey in progress with current limitations, such as separate budgets.	
Description of how services are delivered	
Intermediate Care at home	There is a mix of social care staff and nursing staff. There are two main teams: • reablement • crisis care service – Rapid Elderly Assessment Care Team (REACT).
Step down beds in care homes	This is not currently commissioned, but is being looked at.
Step down beds in community hospitals	Two community hospitals – 30 bed units. A clearer strategic view is needed for them. Could be considered as intermediate care. In practice a mix of supporting palliative and end of life care, delayed discharge, etc. Could it be better commissioned differently with independent sector?
Step up beds in care homes	None
Step up beds in community hospitals	None
Hospital at Home	The REACT team deliver Hospital at Home services.
Reablement services	
Service description	Short term interventions, rehabilitation service, remove or reduce the need for people to use services. Seeking to increase people's independence in health and social care.
Reablement service provision	
Care at home	All
Hospital discharge	All
Others receiving community care services	All
Others in receipt of supported living	All
Do you have a single point of access for these services?	No, a single point of access hub is one of the workstreams in the frail elderly programme.

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Western Isles

Service integration with social care YES The service has been taken forward with the IJB as a physio/OT, nursing and therapeutic discipline and they are currently working on a blended model.	
Description of how services are delivered	
Intermediate Care at home	They currently have some recruiting issues, although the service is operational and regulated/registered with the Care Inspectorate.
Reablement services	
Service description	Bed based reablement services. These are configured within a bespoke group of building-based regulated housing with care at home service. This is not the person's own home, but temporary occupation during their reablement pathway. Step Up and Step Down is also available for any post code holder of the Western Isles. They also have a community-based reablement service at home to the largest population density – but not all Islands.
Do you have a single point of access for these services? If yes: How does that work? If No: Why not?	Yes.
Do you use technology-enabled care?	Yes.

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