ANGUS COUNCIL
SOCIAL WORK AND HEALTH COMMITTEE
4 OCTOBER 2005
ANGUS INDEPENDENT INTERMEDIATE CARE EVALUATION REPORT
REPORT BY THE DIRECTOR OF SOCIAL WORK AND HEALTH

ABSTRACT
The report informs members of the evaluation of the Angus Independent Intermediate Care Scheme.
A copy of the full evaluation is appended to this report.

1 RECOMMENDATIONS
It is recommended that the Social Work and Health Committee:-

i. notes the content of this report;
ii. agrees to the publication of the evaluation.

2 INTRODUCTION

The Angus Independent Intermediate Care Scheme began as a pilot in October 2001. The scheme which operates in partnership with Health, provides short term enhanced support to older people during the transition from hospital to home by offering a period of rehabilitation. The scheme also prevents inappropriate admission to acute in-patient care. Service users benefit from care and rehabilitation as well as comprehensive assessments by nursing, allied health professionals and social work staff.

There are currently 8 beds commissioned in nursing homes in Angus, 2 in the Glens, Edzell and 6 in Cairnie Lodge Arbroath. It was agreed to commission beds in nursing homes to enable this service to be provided in a more homely and less institutional setting than a hospital ward.

2 THE EVALUATION REPORT

The Evaluation report was compiled by the Review Officer for the scheme.

This report outlines the background to the Independent Intermediate Care Scheme and research which supports the Angus model. It is important that Intermediate Care should not be seen as a separate service but a key part of a well integrated system. The Angus model is therefore closely linked with in-patient care services, the Early Supported Discharge/Prevention of Admission Scheme, Care Management and Community health services.

The report also highlights the benefits for both service users and staff in the joint working between the multi professionals involved in the scheme. Feedback from service users was obtained to inform the evaluation of the pilot scheme. Service users reported their satisfaction with the care, which improved their level of
independence and confidence enabling them to return home at the end of their stay.

4  **FINANCIAL IMPLICATIONS**

The financial implications of producing the evaluation report will be contained within the Independent Intermediate Care budget.

5  **HUMAN RIGHTS IMPLICATIONS**

There are no Human Rights implications arising from the recommendations contained in this report.

6  **CONSULTATION**

The Chief Executive, the Director of Law and Administration and the Acting Director of Finance have been consulted in the preparation of this report.

7  **CONCLUSION**

The Angus Independent Intermediate Care Scheme continues to provide valuable enhanced support to older people with the aim of promoting their independence. It provides a flexible approach to how resources are used to achieve positive outcomes for as many people as possible and helps prevent premature placement in long term care.

R Peat  
Director of Social Work and Health

**NOTE:** No background papers, as defined by Section 50D of the Local Government (Scotland) Act 1973 (other than any containing confidential or exempt information) were relied on to any material extent in preparing the above report.
INDEPENDENT INTERMEDIATE CARE
EVALUATION REPORT

FEBRUARY 2005
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Background

Intermediate Care is described in the National Service Framework for Older People as “integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living”.

Independent Intermediate Care is seen as an ideal service to assist with reducing pressure on the acute sector, assist with winter pressure management and reduce the length of hospital admissions. It provides the right type of care at the right time in the right setting.

“Health and Social Care Divide – The experiences of Older People “J Glasby and R Littlechild – states that “Intermediate Care is designed to prevent unnecessary hospital admissions, facilitate swift and timely hospital discharge and prevent premature admission to residential and nursing home care. “Glasby states that according to the Department of Health Circular 2001/001, Intermediate Care should be regarded as describing services that meet ALL the following criteria:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care, or continuing NHS inpatient care;
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment, or opportunity for recovery;
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home;
- Are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less;
- Involve cross professional working, with a single assessment framework, single professional records and shared protocols.

Rationale for Change

A number of policy changes prompted Angus Council to consider Independent Intermediate Care during 2000. These included:

- National Beds Inquiry
- NHS Plan July 2000

In order to consider the national policy, local needs and the aims and objectives of such a scheme a multi-agency steering group was commissioned. The steering group, along with the project team, had to develop a model for intermediate care whilst consulting with clinicians in Ninewells and Stracathro Hospitals and with medical colleagues within the L.H.C.C. They also had to develop the care pathways, criteria and protocols to
enable fair access to the Independent Intermediate Care Service across Angus. The aim of the proposed Pilot (see Appendix 1) was to establish the validity of intermediate care provision in a care home setting.

Some of the key areas for discussion included:

- The size, demography and the range of current local health and social care systems
- The skills and experience of the staff available
- Local management styles
- Local co-ordinators of the scheme and further development.

Steering Group Members were:

Tim Armstrong - Development Manager, Angus Council SWD
Jerry Forteath - Service Manager (Accommodation) Angus Council SWD
Jane Davidson - Bed Utilisation Manager
Liz Myers - Team Manager, Medicine/Cardiovascular
Stuart Aitkenhead - Director of The Glens Care Home
Sheena Kidd - The Glens Manager
Dr. Marc Jacobs - Edzell Surgery
Gordon Thomson - Principal Pharmacist
Angela Murphy - Physiotherapy Manager
Doreen Donald - Occupational Therapy Manager
Gail Smith - Development Manager
Val Sutherland - PAMS, TUHT
There are many examples of Intermediate care schemes, which have been developed and are operated by different agencies. This research considered various projects and schemes already in operation or about to commence before deciding on the agreed Angus model.

**Outlands Resource Centre, Plymouth**

This is a 23-bedded rehabilitation unit opened in 1992. As a result of collaboration between Social Work and the acute health care sector the agreed aim was:

“To gain practical experience of diverting people from residential care at the point of discharge from hospital, by providing a facility which would enable them to make well judged decisions about the future level of support they would need.”

The criteria for admission are similar to those adopted by the Angus scheme. Studies found that the average age for admission is 80 years and clients stay up to 6 weeks for rehabilitation. There are ongoing reviews and discharge planning meetings. The unit has issues with the changing role of the staff and their perceptions of need. Evaluation of the service has indicated that staff have been able to assist people to return home with minimum care packages.

Staff feel the approach worked because:

- Clients know what they are there for
- Care has been taken to maintain a team spirit
- Staff have gained confidence
- Admission criteria have been adhered to.

The Outlands Centre states, “They do not underestimate the complexity of establishing such a complex multi-agency service but are convinced that the shared investment has also reaped shared benefits”.

**Bedford and Luton Community Trust**

Bedford and Luton Community Trust run an Effective Transfer scheme, which supports patients on early discharge from hospital. Social Work and Healthcare jointly fund this project. There is GP, Nursing and Allied Health Professional input. Day care or short-term admissions are offered to continue the rehabilitation process.

**Westminster Healthcare**

An Intermediate Care step-down contract was agreed between Epsom and St Helier NHS Trust and the Westminster Beaumont Care home for a 6-month period between September 2001 and March 2002. Five beds were set aside
for the project. The admission criteria, discharge process and evaluation tool was agreed. Statistical data, highlighted below, was also collected to allow comparison with Epsom General Hospital.

- Average age of service user was 75yrs range from 44 – 95yrs.
- Gender 73% female compared to 27% male.
- The main admissions were for orthopaedic interventions i.e. Hip replacement,
- Remained in Intermediate care an average of 9.2 days, ranging from 3 to 19 days.
- A similar period in Epsom General averaged a length of stay of 12.5 days.
- Bed days saved of 3.3 days.

Consideration of all these projects allowed the Angus steering group to fully discuss their approach and adopt an agreed model for development.
ANGUS INDEPENDENT INTERMEDIATE CARE SCHEME

Rehabilitation as defined by The Rehabilitation Research Unit, University of Nottingham is: “Rehabilitation is an active, collaborative process. It uses all possible measures to help an individual to restore or maintain physical, psychological and social functioning”.

The Angus Independent Intermediate Care Scheme began as a pilot in October 2001. Initially 6 beds were commissioned at The Glens Nursing Home in Edzell. These beds were block purchased from October 2001 until March 2002. The six places commissioned at The Glens provided Independent Intermediate care for individuals leaving hospital. Angus Council Social Work Department agreed to meet the total cost of commissioning the six places for the pilot. (see appendix 2)

The aim of the service was to enhance the support provided for older people (over 65) during transition from hospital to home by offering a period of rehabilitation. The aims were set out as:

- To provide a whole system approach to patient pathway
- In liaison with the Ninewells based co-ordinator to target those patients that would otherwise face unnecessary long hospital admissions
- To prevent inappropriate admissions to acute in-patient care
- To assist in redressing the balance of care, enabling people to be maintained in their local community
- To ease the transition from hospital to the home (medical dependency to functional independence)
- To provide a time limited comprehensive assessment involving nursing, Allied Health Professionals staff and social work staff.
- To ensure a seamless service across the existing Early Supported Discharge/Prevention Of Admission Schemes
- To hold regular reviews to ensure there are continuing needs for active treatment, therapy and maximisation of independence
- To monitor effective use of the Independent Intermediate Care Scheme and other usage accordingly. Monthly reporting mechanism is in place to consider the use of step down, step up, enhanced respite and respite beds.
- To ensure full service user and carer involvement in the process of admission to Independent Intermediate Care and subsequent rehabilitation process
• To provide short term intervention from a few days to 6 weeks
• To ensure an effective, safe discharge from the unit.

Following evaluation it was agreed that Independent Intermediate Care would be a non-chargeable service if Step up, Step down or enhanced respite was approved and that use of spare capacity for respite may be chargeable. It was also agreed that the pilot would continue for a further six months until September 2002 at a reduced capacity of four beds. Further consideration was given to a second scheme to cover the coastal area of Angus.

Measures of Success

During the pilot the success measures considered were:

• Cost compared with hospital care.
• Number of acute bed days saved.
• Level of functioning - Physiotherapy and Occupational Therapy to use a validated outcome measure on administration to and discharge from the Unit.
• Medical input - number of contacts and time provided by the G.P.
• Patient, relative/carer satisfaction – Questionnaire (See Appendix 3).

During the initial pilot the occupancy rate was 63.5% as acceptance onto the scheme was limited to Monday to Thursday (office hours.) Following evaluation, the Early Supported Discharge/Prevention of Admission Team Co-ordinators accepted service users onto the scheme seven days per week up to 9pm via the Social Work Link Worker.

An evaluation was carried out within the coastal area to consider bed availability, understanding of the Independent Intermediate Care ethos, review procedures and availability of suitable resources/room for Allied Health professionals. Following this evaluation, in December 2002, it was decided to increase the scheme with a further 4 beds at Cairnie Lodge Nursing Home in Arbroath. This provided a greater degree of choice with regard to location and met the needs of landward and coastal areas.

During August 2003 the Independent Intermediate Care/Early Supported Discharge group and Head of Service for Older People further evaluated the scheme.

Given the bed occupancy statistics and location of service users it was decided to change the bed capacity from 4 beds at each unit to 2 in the Glens and 6 in Cairnie Lodge.

Between November 2003 and March 2004 an extra place was made available to assist with winter pressures and aid appropriate timely discharge from hospital. Separate statistics were kept on this bed occupancy rate.
The Clinical Governance Group developed service user and carer evaluation forms. The Hospital Co-ordinator undertook 9 telephone interviews. Service users reported a high degree of satisfaction with the care they received whilst at The Glens.

Almost 70% of service users indicated that without the period of intermediate care they would have either been unable to return home or would have been unable to cope at home. Relatives expressed a high degree of satisfaction with the care provided, and indicated that the service had reduced the need for hospitalisation or longer-term care.
Joint Working

During the Independent Intermediate Care Project there has been effective multi-agency working as partners have recognised the need for joint working. This has allowed the opportunity to look at the wider risk base when considering admissions to units. It has also allowed consideration of interagency perspectives and the professional reputations of each partner agency. Staff have had the opportunity of working within a new and specialised field. Stakeholders were Angus Council Social Work and Health department, Tayside Primary Care Trust, GP’s and the private sector.

An evaluation of staff highlighted:

- The facilitation of effective joint working.
- Homely environment allowing more scope for the development of independent living skills.
- Seamless care.
- Staff have benefited from being able to develop skills.
- Twenty-four hour care and security for the service user.
- Enhances the range of community interventions.

The Single Shared Assessment tool has been invaluable as a method of ensuring appropriate sharing of information across disciplines. All agencies involved in the Independent Intermediate Care scheme promote its use and provide information to other professions across Angus.

Service users and carers are made aware of the purpose of the placement prior to admission either by the Hospital based Co-ordinator, or by the community based referring agency. Service users are informed that this is an opportunity for short-term rehabilitation with the aim of maximising independence and promoting a safe discharge back into the community. They have to agree to actively participate for the process to be effective. The purpose of review meetings is explained to service users and carers as being:

- To plan the assessment of need
- To consider identified need and how this will be met
- To actively plan for discharge from the unit
- To plan/ensure services are in place on discharge

Reviews are held on a weekly basis or as needs dictate and an easy working rapport and excellent communications links have developed.

Staff within units have embraced the concept of Independent Intermediate Care and are positive about the impact this has had. Staff have had opportunities for further training and have developed a clearer understanding of community care principles. Nursing and care staff have appreciated the opportunity to participate in reviews, assist in therapeutic intervention and carry out treatment programmes set out by the Allied Health professions.
involved. They are aware that this is a change in the culture from the medical model to one of rehabilitation, prevention of deterioration and maximising skills.

Intermediate care contributes to the whole system approach when it is pro-active rather than re-active. Staff involved have to promote risk management.

Monitoring and audit of the service is assured through quarterly multi-disciplinary meetings chaired by the Service Manager for Homecare. These meetings allow for discussion about changes in criteria, practical issues, and new ideas and ensure the continued appropriate use of the service as well as clear lines of accountability. Issues, including unmet needs and needs within specific units, are discussed and recorded in the minutes of the meetings. Several changes to the criteria have been made over the last three years to expand the service i.e. use of spare capacity for enhanced respite or carers respite.

The scheme is deemed to be successful as all involved are aware of the principles of the scheme and their role within it.
Summary

“Intermediate Care has by far the largest potential to improve hospital discharge practices” (Glasby J, Hospital Discharge Integrating Health and Social Care).

As Independent Intermediate Care has developed it has not only assisted service users to move from the hospital setting to care closer to home but has prevented unnecessary hospital admissions. Independent Intermediate Care provides a more flexible approach to resource utilisation. It ensures a co-ordinated approach throughout the patient pathway with the service user at the centre actively involved in decision-making, assessments, reviews and discharge planning. An expansion of the criteria has allowed for short-term respite should a primary carer be admitted to hospital, therefore stopping inappropriate care admissions.

A positive factor in the development of the scheme has been a single link worker within Social Work. This has ensured one contact point for staff to discuss possible admissions, criteria, appropriate paperwork and referral routes. It has enabled a flexible approach when using spare capacity and use of the unit for delayed discharges/ carer’s respite or assessment facilities in order to more fully assess needs. Having a single gatekeeper ensures each case can be discussed and considered and other options i.e. ESD/POA, hospital admission can be evaluated.

Independent Intermediate care should be seen as “a bridge and a diversion: a bridge between the different environments of hospital and home; and a diversion from hospital admission through investment in individual and community capacity building ‘upstream’ in order to reduce demand pressures on hospitals ‘downstream’”. (News from the Nuffield Autumn 2002.)
CRITERIA FOR REFERRAL TO INDEPENDENT INTERMEDIATE CARE

STEP UP CARE AND STEP DOWN CARE

1. All Angus residents will be considered for this service.

2. Patients should be 60 years of age or over and agree to independent intermediate care.

3. Patients needs will have been assessed as being unable to be met via ESD/POA at present.

4. Patients within medical/surgical/orthopaedics wards in Ninewells Hospital, wards 2 and 3 Stracathro Hospital, Arbroath Infirmary or Angus Community Hospitals will be considered for step down care.

5. Service users living at home and in residential care will be considered for step up care.

6. Patients in hospital who have been identified as being medically fit for discharge to independent intermediate care but not ready for discharge home will be considered for step down care. They must not require further acute medical intervention.

7. Where capacity allows service users who are potentially delayed discharges due to a need for minor adaptations or care packages at home could be managed for up to 2 weeks in intermediate care if they have a foreseeable discharge date within this period.

8. Appropriate patient groups may include:
   - Frail Elderly: reduced mobility, chest infection, UTI, exacerbation of COPD.
   - General Surgery: surgical rehabilitation patients.
   - Orthopaedics

9. Patients/service users will be deemed to require short-term (up to four weeks) support/assessment/rehabilitation to facilitate a safe discharge to their own home or to avoid an admission to hospital.

10. All patients referred should have an appropriate assessment by key therapists.

11. Staff should follow the Joint Health and Social Work Discharge Policy.
**STEP UP INDEPENDENT INTERMEDIATE CARE GUIDANCE NOTES**

- GPs, District Nurses, Occupational Therapists and Physiotherapists, Care Managers and Home Care Assessors can make referrals for step up into intermediate care.

- Referrals can be made 9am – 9pm Monday to Sunday.

- Prior to the referral being made it is expected that an assessment will have been carried out by the GP, District Nurse, OT, PT or Social Work Case Holder in a similar way to the Prevention of Admission scheme. This assessment is essential in order to access Occupational Therapy and Physiotherapy services whilst in the care home.

- The referrer must copy SSA1 and relevant sections of the SSA2 to Team Leader or designated deputy and the relevant care home. The referrer should also copy the SSA1 to the Occupational Therapist and Physiotherapist where appropriate.

- Team Leader or designated deputy will screen the referral to ensure the person meets the criteria for step-up intermediate care and determine if there is a bed available in the care home.

- If the person being referred does not meet the criteria or a bed is not available the use of the Prevention of Admission Scheme will be discussed with the referrer.

- Team Leader or designated deputy will discuss admission with the care home and advise the referrer of the outcome of discussion e.g. if referral is made in late evening it may be more appropriate to arrange admission for the following day and use POA to provide overnight care.

- It is the referrer’s responsibility to arrange transport to the care home.

**STEP DOWN INDEPENDENT INTERMEDIATE CARE GUIDANCE NOTES**

- Access to step down intermediate care is always via the Hospital Co-ordinator.

- The Hospital Co-ordinator will complete the assessment and liaise with the care home and Team Leader or designated deputy to check bed availability.

- The Hospital Co-ordinator will send assessment information to Team Leader, care home, Occupational Therapist, Physiotherapist, patient’s GP and the GP responsible for the clients medical care while in Independent Intermediate Care.
REFERRAL CRITERIA FOR ENHANCED RESPITE CARE WITHIN THE INDEPENDENT INTERMEDIATE CARE SCHEMES

1. All Angus residents, irrespective of address in Angus will be considered for enhanced respite care.

2. All enhanced respite care must be authorised by Team Leader or designated deputy.

3. Service users should be aged 60 years or over and agree to the provision of enhanced respite care.

4. Enhanced respite care will be provided for a maximum of 2 weeks.

5. Enhanced respite will only be authorised where there are at least two spare beds within the scheme.

6. Service users must not require acute medical intervention.

7. Service users will have been subject to a comprehensive single shared assessment including where appropriate specialist Occupational Therapy and Physiotherapy assessment prior to admission to the care home.
ENHANCED RESPITE CARE/ RESPITE CARE GUIDANCE NOTES

- Access to respite care or enhanced respite care is via Team Leader or designated deputy.

- Persons making a referral will be expected to complete an assessment that clearly identifies the need for rehabilitation services within a care home environment. Where possible an Occupational Therapy or Physiotherapy pre-admission assessment is desirable.

- Respite can be provided to support carers and facilitate an early discharge from hospital. Clients will be assessed by the Hospital Co-ordinator.

- Respite and enhanced respite will be limited to 2 weeks.

Contacts

Hospital Based Co-ordinator
Ninewells Hospital
Dundee
Tel. 01382 496521
Mob. 07803 673529
Fax. 01382 632810

Social Work
Team Leader
Tel. 01241 857206
Fax. 01241 854616
CRITERIA FOR USE OF SPARE RESPITE CAPACITY

- All access to or respite care must be authorised by the designated Service Manager
  - Planned respite will only be authorised where there are at least three spare beds within the residential unit.
- Vacancies should not be used for respite if they are being considered for use under the scheme within the next seven days.
- Emergency respite will only be authorised where at least one other vacancy exists.
- No planned respite will be authorised over major holiday periods unless cleared by the Head of Service.
<table>
<thead>
<tr>
<th>Scheme</th>
<th>Priority for use of beds</th>
<th>Source of Referral</th>
<th>Assessment Documentation (SSA1) Completed by:</th>
<th>Approved by:</th>
<th>Notes</th>
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<tbody>
<tr>
<td><em>Step Down</em> (To promote discharge)</td>
<td>1</td>
<td>Wards to Hospital Co-ordinator</td>
<td>Hospital Co-ordinator</td>
<td>Hospital Co-ordinator</td>
<td>Liase with Team Leader to confirm availability and use of bed.</td>
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<tr>
<td><em>Step Up</em> (To prevent admission)</td>
<td>2</td>
<td>GP’s/DN/OT/PT/HCA Care Manager to Community Co-ordinator</td>
<td>Referrer</td>
<td>Team Leader or deputy</td>
<td>Liase with Team Leader to confirm suitability for IICS and bed availability</td>
</tr>
<tr>
<td><em>Enhanced Respite Care</em> (Respite Care with OT/PT support)</td>
<td>3</td>
<td>Care Managers / HCA, OT’s/PT’s, DNs, GPs to Community Co-ordinator</td>
<td>Referrer</td>
<td>Team Leader or deputy</td>
<td>Liase with Team Leader to confirm suitability for IICS and bed availability and use of bed.</td>
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<tr>
<td><em>Respite Care</em></td>
<td>4</td>
<td>Care Managers to Community Co-ordinator</td>
<td>Care Manager</td>
<td>Team Leader or deputy</td>
<td>Liase with Team Leader to confirm suitability for IICS and bed availability and use of bed.</td>
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### CRITERIA CHANGES 2001 –2004

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<th>2001</th>
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<tbody>
<tr>
<td>Over 65 years</td>
<td>65 years</td>
<td></td>
<td>Over 60 years</td>
</tr>
<tr>
<td>Short time Rehabilitation</td>
<td>3 weeks</td>
<td>4 - 5 weeks</td>
<td>Up to 6 weeks</td>
</tr>
<tr>
<td>Medical and Surgical Wards for step down only</td>
<td>Ward Specific</td>
<td>Included orthopaedic wards</td>
<td>Medical/Surgical and Orthopaedics at Ninewells. Ward 2 and 3 Stracathro Arbroath Infirmary Angus Community Hospitals</td>
</tr>
<tr>
<td>Admission times</td>
<td>Monday - Thursday 9 a.m. - 5 p.m.</td>
<td>Use of ESD/POA Co-ordinators result in 7 days service</td>
<td>7 Days up to 9.00 p.m.</td>
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<tr>
<td>Spare Capacity</td>
<td></td>
<td>Use for delayed discharges Respite Assessment facility</td>
<td>Delayed discharges - waiting on minor adaptations/rehousing Choice of Unit</td>
</tr>
<tr>
<td>Respite Provision for spare capacity</td>
<td>Has to be authorised by Service Manager</td>
<td>Respite authorised by Social Work Team Leader. Use for Enhanced Respite and Respite</td>
<td>Respite Carers Respite Enhanced Respite Provision via OOH/ESD</td>
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1. Occupancy Levels 1.04.04 – 30.09.04

2. Occupancy Levels January – December 2003
   Bed Days Saved January – December 2003

3. Average Age January – December 2003
   Gender January – December 2003

4. Type of Care – The Glens
   Type of Care – Cairnie Lodge

5. Source of Referrals – Community
   Source of Referrals – Hospitals

6. Outcomes – The Glens
   Outcomes – Cairnie Lodge

7. Statistics Data
### INTERMEDIATE CARE BEDS OCCUPANCY FIGURES

1 April 2004 - 3 September 2004

<table>
<thead>
<tr>
<th></th>
<th>CAIRNIE LODGE</th>
<th>THE GLENS</th>
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<tr>
<td>Established beds</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Apr-04</td>
<td>67%</td>
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<tr>
<td>May-04</td>
<td>33%</td>
<td>47%</td>
</tr>
<tr>
<td>Jun-04</td>
<td>67%</td>
<td>83%</td>
</tr>
<tr>
<td>Jul-04</td>
<td>58%</td>
<td>65%</td>
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<tr>
<td>Aug-04</td>
<td>70%</td>
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</tr>
<tr>
<td>Sep-04</td>
<td>80%</td>
<td>37%</td>
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#### Occupancy Levels April 04 - September 04

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<td>Apr-04</td>
<td>120</td>
<td>31</td>
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<tr>
<td>May-04</td>
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<td>Jun-04</td>
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<td>Jul-04</td>
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<td>Aug-04</td>
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<tr>
<td>Sep-04</td>
<td>128</td>
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#### OCCUPANCY LEVELS

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<td>Apr-04</td>
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<tr>
<td>May-04</td>
<td>61</td>
<td>29</td>
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<td>Jun-04</td>
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<td>50</td>
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<td>Jul-04</td>
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<td>Aug-04</td>
<td>130</td>
<td>25</td>
</tr>
<tr>
<td>Sep-04</td>
<td>128</td>
<td>22</td>
</tr>
</tbody>
</table>
Cairnie Lodge
Occupancy in Days
January-December 2004

The Glens
Occupancy in Days
January-December 2004
Source of Referrals - Hospitals
January - December 2003

Source of Referrals - Community
January - December 2003
Outcomes - The Glens

- Home with Same Services: 37%
- Home with Additional Services: 22%
- Home with New Services: 3%
- Long Term Hosp Care: 5%
- Permanent Care: 20%
- Died: 10%
- Hospital: 3%

Outcomes - Cairnie Lodge

- Home with Same Services: 47%
- Home with Additional Services: 26%
- Home with New Services: 8%
- Permanent Care: 6%
- Died: 8%
- Hospital: 2%
- P & V Respite: 3%
Bibliography


King’s Fund (2002) Rehabilitation and intermediate care publications


Stevenson, J and Spencer, L Developing intermediate care – A guide for Health and Social services Professionals.


Society Guardian.co.uk Intermediate care (questions and answers).

Wilson, K and Stevenson, J (2001) Intermediate care co-ordination: King’s Fund


News from the Nuffield, Autumn 2002.
APPENDIX 1

INDEPENDENT INTERMEDIATE CARE PILOT

Potentially, intermediate care can be provided in many settings, from community hospital wards to acute hospitals and services delivered in the patient’s own home.

The aim of the Pilot is to establish the validity of intermediate care provision in a care home setting.

Duration

1. The Pilot will run for 26 weeks from 1st October 2001 to 31st March 2002

The Patient

2. The Pilot will focus on the provision of intermediate care for patients over 65 years old requiring nursing / rehabilitation before they can be returned home.

3. To be included in the pilot patients will match the following criteria:
   a. Over 65
   b. Require a period of nursing / rehabilitation / community care assessment / intervention prior to returning home. This period of intervention is likely to be approximately 3 weeks but should be no more than 6 weeks in duration.
   c. No longer require acute hospital care

The Procedure

4. The following procedures will apply during the Pilot:
   a. The hospital-based co-ordinator, in consultation with the multi-disciplinary team, will determine if intermediate care is suitable.
   b. The hospital-based co-ordinator will arrange a joint assessment in consultation with the community-based co-ordinator and care home.
   c. Intermediate care package agreed between care home and co-ordinator
   d. After transfer to the care home setting, responsibility for additional medical problems will lie with the local GP, who will refer any unforeseen medical problem to the Acute Care Physician. The GP will visit patients on admission to the care home and thereafter as necessary.
   e. Intermediate care will be provided under contract between Angus Council Social Work and Glens Residential Nursing Home Edzell
f. The care manager, identified team and Glens Residential Nursing Home will monitor progress following the agreed discharge protocol.

g. Admissions will be received Monday to Thursday

Care Homes

5. For the purpose of the Pilot, Angus Council Social Work will purchase 6 beds. Angus Council Social Work will be able to use spare capacity for respite care etc.

Professional Services

6. The following services, resourced from the Early Supported Discharge/Prevention of Admission scheme, will be available for the duration of the pilot:

   a. Physiotherapist – Monday – Friday (2 hours per day) (1 Hour per day) physio assistant
   
   b. Occupational Therapist – Monday – Friday (2 hours per day)

Record Keeping and Evaluation

7. Procedures will put in place before the Pilot commences to ensure effective evaluation can be undertaken. It is envisaged that each of the groups involved will carry out their own evaluation and contribute to the overall evaluation of the Pilot.

8. The views of those receiving the service will be collected and inform the evaluation.

9. The steering group will report to the Angus Joint Commissioning Group within 6 weeks of the end of the pilot.

Success Criteria

10. a. Success criteria should be agreed by NHS Tayside and Angus Council Social work before the pilot commences.

   b. Success criteria should include

      1. Cost compared with hospital care
      2. Number of acute bed days saved
      3. Level of functioning using a validated outcome measure
      4. Number of contacts and time provided by GP
      5. Patient, carer and relative satisfaction.
FIVE PATIENT JOURNEYS

Five main patient journeys are envisaged. There may be variations depending on prevailing individual circumstances. The five main journeys are:

1. Directly home without any further interventions
2. Directly home with ESDS
3. Intermediate Care in care home setting then discharged home
4. Intermediate Care then discharged home with Early Supported Discharge
5. Community Hospital patient requiring Intermediate Care then discharge home (following all agreed criteria)
CRITERIA FOR REFERRAL TO INDEPENDENT INTERMEDIATE CARE

1. All patients in Angus will be considered for this pilot

2. Patients should be over 65 years of age and agree to independent intermediate care

3. Patient’s needs cannot be met via ESDS at present

4. Patients require to be discharged from medical/surgical wards, Ninewells / Stracathro or Community Hospitals to be considered for independent intermediate care.

5. Patients identified as medically fit for discharge to independent intermediate care but not ready for discharge home. They must not require further acute medical intervention.

6. Appropriate patient group may include;
   - Frail Elderly: reduced mobility, chest infection, UTI, exacerbation of COPD
   - General Surgery: surgical rehabilitation patients

7. Patients predicted to require short-term / support / assessment / rehabilitation to facilitate a safe discharge to their own home, normally within 3 weeks.

8. Patients identified by multi-disciplinary team facilitated by Co-ordinator

9. All patients referred should have an appropriate assessment by key Therapists

10. Joint Health Social Work Discharge Policy should be followed
FLOWCHART FOR IDENTIFICATION OF PATIENT FOR INDEPENDENT INTERMEDIATE CARE AND REFERRAL PROCESS

- Hospital TPCT Co-ordinator to discuss IIC with patients and obtain agreement
- When appropriate, relatives to be informed/consulted by Co-ordinator

- Patient identified as medically fit for discharge to independent intermediate care but inappropriate for discharge home at present. They must not require further acute medical intervention. Patients predicted to require short-term support / assessment rehabilitation to facilitate a safe discharge to their own home.
- Patients needs cannot be met via ESDS at present
- Patient identified by multi-professional team as appropriate for Independent Intermediate Care (facilitated by Co-ordinator – name to follow)

Co-coordinator/named nurse to arrange Hospital based AHP assessment(s) to be carried out if not previously completed

- Hospital Based Co-ordinator to liaise with Community based co-ordinator
- Hospital based Co-ordinator notifies patients own GP and faxes referrals to appropriate PAMS also notifying Mark Jacobs

- Liaising link made with Nursing Home by Community Co-ordinator
- Transport arrangements to be made by named nurse – usual transfer procedure
- Arrangements re transfer of patient to Nursing Home (Standard discharge form to be completed by medical staff and nursing transfer letter by Named Nurse)
- Arrangements made re transfer of AHP information to appropriate AHP Team Member
- Notification to SWS re potential discharge arrangements

Transfer of Patients (Relative, Private Car, NHS Transport) – Monday to Thursday
HOSPITAL BASED AHP PROTOCOL

Protocol for referral and assessment for Independent Intermediate Care Model (IIC)

- Therapists will be available to assess between 9.00am and 4.00pm Monday to Friday except on Public Holidays
- To ensure a same day response a verbal referral should be given to the Key Therapist by the Co-ordinator prior to midday followed by the written referral
- Patients will receive an assessment within 3 working hours of referral dependent on priority caseload and staffing levels
- Therapists will inform the Co-ordinator of the patient’s suitability for IIC and provide a report of their assessment
- Co-ordinator must then obtain patient’s consent to go into IIC
- Co-ordinator to liaise with ESDS AHP Team
- Occupational Therapy and Physiotherapy reports will be faxed to the ESDS Therapists
ESDS AHP PROTOCOL

Following acceptance onto the pilot and transfer to The Glens Nursing Nome:

- Faxed referral and reports will be received from the hospital based co-ordinator

- Initial ESDS and AHP assessment will be carried out next working day whenever possible/appropriate

- Goals set to realistic time-scales (14 days preferably) weekly at maximum but will be reviewed as necessary

- Treatment programme initiated with ongoing communication with other health professionals involved (i.e. nursing and GP)

- Individual time spent with named nursing staff re rehabilitation ethos, specific goals and approaches

- When goals are met the Team will be informed and organisation of discharge arrangements will be discussed. Local GP to decide date of discharge after input from team

- Discharge date confirmed / all parties aware

- Discharge report / letter to be forwarded to Local GP/Co-coordinator/patient’s GP and Clinical Governance Facilitator

- Transport arrangements made by Care Home.

IF GOALS NOT MET

Liaise and discuss with team

Return to hospital if medical condition an issue

Consider other appropriate alternatives
ESD AHP DISCHARGE CRITERIA

- Goals met
- No Progress
- Progress plateau
- Self Discharge
- Patient Non-compliance
- AHP input no longer appropriate – severe deterioration in condition.
1. Patient identified as suitable for Independent Intermediate Care

2. Discharge prescription written by Doctor and checked by Clinical Pharmacist

3. A 7 day supply of medicines supplies on discharge in accordance with Tayside Discharge Protocol

4. Copy of discharge prescription faxed to Edzell GP surgery and Community Pharmacist by Hospital based Co-ordinator

5. Patient registered as temporary resident with local GP on transfer to Care Home

6. Prescription for ongoing medication written by GP within 5 days of transfer and sent to Community Pharmacy in accordance with normal procedures

7. Prescriptions dispensed by Community Pharmacist in accordance with normal procedures.

8. Medicines provided in form suitable for use in Care Home and at discharge

9. Any new medicines required during stay in Care Home to be prescribed by local GP and dispensed by Community Pharmacist

10. Prior to discharge from Care Home, a summary letter including ongoing medication requirements, to be sent by the Care Home, to patients own GP and usual Community Pharmacist to ensure ongoing supply.

11. On leaving the Care Home the patient should have a minimum of 7 days supply of medicines.
1) On receipt of a relevant referral, the hospital-based co-ordinator will contact the Stracathro Clerical Support to identify any social work input.

2) The co-ordinator will fax the referral to the, Social Work Office, Brechin (01356 623636) to be logged on a database and a copy forwarded immediately to the case holder.

3) Where the individual is not previously known to Social Work the referral will be allocated to the Stracathro-based Care Manager, otherwise the existing Care Manager or Home Care Assessor will continue to hold case responsibility.

4) Relevant social work staff will contact the hospital-based co-ordinator and a decision will be made as to the status of the referral.

5) Ongoing liaison should take place between the hospital-based co-ordinator and the Care Manager/Home Care Assessor regarding discharge arrangements.

6) A record of the usage of the places within the residential unit/nursing home will be maintained at the Brechin Social Work Office, Panmure Street, Brechin, Tel. 01356 624771.

7) An updated record of the availability of places within the unit will be faxed weekly, on a Monday morning, from the Brechin Office to Hospital based co-ordinator.

8) The hospital-based co-ordinator will complete Part A of the Monitoring Form and pass the form to the residential unit/nursing home when the service user is placed.

9) It is the responsibility of the Care Manager/Home Care Assessor to update K2 using form CCM6 when the service user is placed within the unit.

10) The care manager/assessor must ensure that a full financial assessment is undertaken as soon as possible, and that claims for benefits are made where appropriate (CCM7). The care manager/assessor should ensure that the Benefits Agency is informed of the placement. If the service user and/or his or her carer are unable to do this themselves the benefits agency should be informed by the care manager/assessor using the standard Fax for this purpose.

11) Case reviews will be held on Wednesday mornings at the residential unit/nursing home. This will ensure an initial case review is held within a week of admission to the residential unit. The Team Leader
Brechin/Montrose will chair case reviews. Social Work staff (i.e. Care manager/assessor) and residential/AHP/Medical staff should attend. A target date for discharge should be set and arrangements for monitoring progress towards this date put in place.

12) The residential unit/nursing home will maintain a record of all professional input to the service user. This information will be used to complete Part B of the Monitoring Form.

13) The hospital care plan should follow the individual to the care home. The residential unit/nursing home should complete a care plan to address the individual's care while in the unit. The care manager should initiate a comprehensive assessment on admission to the unit and begin completing a care plan to facilitate and support the individual's return home as soon as possible (CCM2 or CCM2.1).

14) A second review meeting should be held within 10 working days on or on the day prior to discharge if this is sooner. This should be convened and chaired by the Team Leader B/M. Any further review should be held fortnightly.

15) Discharge of the service user will result in the Care Manager/Home Care Assessor updating K2 (CCM6).

16) A package of relevant support, including home care services should be put in place to help facilitate any discharge from the residential unit/nursing home. *Those leaving the unit will not be eligible for support under the Early Support Discharge Scheme as this scheme relates to discharge from hospital.*

17) Eligibility for 4 weeks of home care starts from discharge from hospital. i.e. An individual leaving hospital and staying in the residential unit/nursing home for two weeks will be eligible for two further weeks of free home care. An individual staying in the residential unit/nursing home for four weeks will not be eligible for any further free home care. Note: Those leaving Ninewells to move to the residential unit/nursing home are also eligible for free home care.

18) Part B of the Monitoring Form must be completed by the residential unit/nursing home and passed to the Care Manager/ Home Care Assessor when the service user leaves the unit. The Care Manager should complete Part C of the monitoring form and return the whole form to the Social Work Office. Brechin.

19) All services provided to the service user whilst within the residential unit/nursing home must be recorded on the form maintained by the residential unit. This form must be completed and signed on each visit by a member of social work or AHP staff.
20) When the service user leaves the residential unit/nursing home they should leave with at least 7 days medication.

21) On discharge from the residential unit/nursing home staff should contact the district nursing service in the service users home area to ensure adequate nursing support is in place.

22) On discharge from the residential unit/nursing home the local GP should contact the service users own GP to ensure adequate medical care is in place.

23) On discharge from the residential unit/nursing home any AHP input will be transferred to the AHP service in the service user’s home area.

24) Transport home is the responsibility of the service user. Where the lack of transport is causing difficulties or is likely to lead to a delay in returning home, social work staff should facilitate access to transport. Where a stretcher transfer is required this is a Health responsibility and appropriate liaison should take place to ensure this takes place without unnecessary delay.

25) It is the responsibility of the designated service manager to maintain an overview of the use of the residential unit/nursing home.

26) The Benefits agency should be faxed when the service user leaves the unit. Where a service user was in receipt of Attendance Allowance, which has been withdrawn, the Disability Benefits Centre in Blackpool Tel. 0345 123456 must be informed that the service user has returned home.
REVIEW MEETINGS – INTERMEDIATE CARE PILOT PROJECT

Purpose of Review Meetings

- To plan the assessment of need
- To consider identified need and how this will be met
- To plan for discharge from the residential unit
- To plan/ensure services are in place on discharge

Nature of Meeting

It is anticipated that care reviews will last up to half an hour depending on the complexity of the situation. The review meeting will focus on the care needs identified during the stay in intermediate and the projected care needs on return home.

Who Should Attend

- Chair
- The identified case worker
- A representative from the residential unit
- A GP (Where there are identified medical issues)
- AHP Staff (Where individuals are directly involved with the service user)
- Carer/Relative (It is essential that carers are involved in the review meeting immediately prior to discharge)

Written Reports/Documentation

The caseworker or an alternative minute taker will record the discussion on form CCM5. This should be typed up and circulated to arrive at least one day prior to the next review meeting. The care plan (CCM2) should be compiled or updated at the review meeting. This should be amended and circulated with the minutes of the review meeting. Existing care plans should be forwarded to the Chair prior to the first review meeting.

Future Review Meetings

At the end of each review a date and time for the following review should be agreed and recorded in the review minute.
Involving Carers/Relatives

It is the responsibility of the caseworker to ensure that carers/relatives are informed of the purpose and nature of care reviews and are assisted to attend if desired. Care reviews should not be seen as the only opportunity for carers/relatives to ask questions about an individual's care. Carers/relatives should be encouraged to clarify any concerns/questions with relevant staff outwith the care review.
INTERMEDIATE CARE - CONTACT MONITORING SHEET

This form should be used to record all contact from staff with service users who are part of the Intermediate Care Pilot Project

Surname: ____________________  CHI No. ______________________

Forename: ___________________  URN No: _____________________

Date of Birth:  Date of Admission: __________________

Home Address: _________________________________________________

<table>
<thead>
<tr>
<th>Date and Time of Contact</th>
<th>Nature of Contact</th>
<th>Length of Contact</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. 01/10/01 3:30pm</td>
<td>Visit by OT</td>
<td>35 mins</td>
<td></td>
</tr>
</tbody>
</table>

Date of Discharge: ______________

**Note:** Information from this form should be transferred to the main monitoring form before it is passed to the Care Manager
1. INTRODUCTIONS AND BACKGROUND

In August 2001 detailed proposals to develop a pilot project to provide intermediate/step-down care from hospital were developed and approved by the Angus Joint Commissioning Group. The final project proposal is appended to this report (Appendix 1).

The aim of the pilot was to establish the validity of intermediate care provision in a care home setting.

A project steering group was established to oversee the operation of the pilot. Details of the membership of the steering group are included within the project proposal document.

The pilot proposal became operational on 1 October 2002 and was scheduled to finish on 31 March 2002. It was agreed to continue the pilot project for a further six months till 30th September 2002 at a reduced capacity of 4 beds. This further period allowed the Angus Joint Management and Commissioning Group to consider the evaluation report and, dependant upon outcome, for Angus Council social work to undertake a relevant tendering exercise.

1.1 INTERMEDIATE CARE

Throughout the period of the pilot it became evident that the agencies involved had different understandings/perceptions as to what constituted Intermediate Care. There is a need for further work to develop a clear joint definition for “intermediate care”. This will allow this type of provision to be set alongside the provision that can be provided by other resources such as community hospitals. It will also ensure that the criteria for this type of care are revisited to ensure that the resource is being used to its maximum effectiveness.

2. THE PILOT

The pilot project comprised 6 places commissioned by Angus Council social work at the Glens nursing home in Edzell providing intermediate care for individuals leaving a hospital setting. The aim of the service being to enhance the support provided for older people (Over 65) during the transition from hospital to home by offering a period of rehabilitation.

Medical care whilst at the Glens is provided by the local GP. This input is however on a temporary patient basis and as such it is an essential referral criterion that individuals are fit for medical discharge. Whilst at the Glens additional AHP support is available to facilitate rehabilitation. The time at the
Glens also allows for a detailed assessment to be undertaken ensuring appropriate community care services are in place for the return home.

The project steering group developed detailed criteria for referrals. These are included within the finalised project proposal Appendix 1. Appropriate referral and monitoring documentation were also developed.

3. RESOURCES

Angus Council Social Work has met the cost of commissioning the 6 places for the pilot project. In addition Tayside Primary Care Trust has received £30,000 from THB winter pressure monies to cover additional GP and AHP costs for the period from October 2001 to March 2002

3.1 CHARGING

During the pilot Angus Council Social Work made no charge for the provision of care. It is however noted that a patient coming into the Glens from hospital on income support is eligible to receive their full personal allowance plus a residential allowance of £63.30 per week for their accommodation costs. In effect this means that individuals are significantly financially better off. From 1st April the residential allowance will transfer to the local authority and new placements after this date will not receive this allowance.

4. CARE PLANNING

The social work department has developed procedures for staff regarding the care planning process for individuals accepted onto the scheme This involves regular review meetings. There has been some difference of opinion as to whether relatives should attend these care planning meetings.

These guidelines have been developed around the pilot at the Glens. If the decision is taken to continue Intermediate Care provision either at the Glens or at another Unit these guidelines will require to be reviewed.

5. USE OF SPARE CAPACITY FOR RESPITE CARE

The original project outline allowed for the use of spare capacity within the Glens for respite care. The social work department developed criteria for this usage.

6. ACTIVITY

The following activity levels relate to the period October 2001 to March 2002.

6.1. REFERRALS

A total of 37 referrals were made to the pilot during the period in question.
Unsuccessful Referrals | 20
Successful referrals  | 17
Total                | 37

6.2 SUCCESSFUL REFERRALS

<table>
<thead>
<tr>
<th>Male</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

Home Address

| Arbroath | 2 |
| Montrose | 5 |
| Monifieth | 2 |
| Muirhead | 1 |
| Forfar | 3 |
| Kirriemuir | 2 |
| Edzell | 1 |
| Brechin | 1 |
| Total | 17 |

Note: There would seem to be little correlation between the addresses of the successful referrals and the location of the Glens Nursing Home.

Reason for Referral/Primary Diagnosis

| Further Rehabilitation | 6 |
| Myocardial infraction | 2 |
| Social Admission | 1 |
| Iron Deficiency | 1 |
| Respiratory Tract Infection | 1 |
| Pneumonia | 1 |
| Multiple | 1 |
| Dynamic hip screw fixation | 1 |
| Fractured clavicle | 1 |
| Dislocated (R) Thomson’s Hemiarthoplasty | 1 |
| Fractured Pubic Rami | 1 |

Average Age 84 years

Note: The relatively high age of those being placed in the Glens reflects the high dependency needs.

Average length of time
From referral to placement 5 days (Range 0 – 10 days)

There are a variety of reasons identified for the longer time delays between referral and placement. For example some individuals became unwell and the
assessment was put on hold until they were well enough to be reconsidered for the service.

**Average length of placement** 31 days (Range 11-64 days)

It should be noted that some of the longer time scales relate to the individuals who did not return home and subsequently waited within the Glens until a permanent placement was identified. These individuals artificially increase the average length of placement. It is recognised that there is a need to develop a clear exit strategy for those individuals who are unable to return home from the provision.

**Source of placement referrals**

<table>
<thead>
<tr>
<th>Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ninewells</td>
<td>13</td>
</tr>
<tr>
<td>Stracathro</td>
<td>3</td>
</tr>
<tr>
<td>MRI</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

The high proportion of successful referrals from Ninewells mirrors the same high proportion in the unsuccessful referrals. There is a view that one reason for this is the fact that the Hospital Co-ordinator is based at Ninewells. There would seem to be scope for further promotion of the service within the community hospitals in Angus.

**Outcomes**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home with additional mainstream services</td>
<td>6</td>
</tr>
<tr>
<td>Home with no additional services</td>
<td>4</td>
</tr>
<tr>
<td>Home with new service provision</td>
<td>2</td>
</tr>
<tr>
<td>Permanent care</td>
<td>3</td>
</tr>
<tr>
<td>Still resident at the Glens</td>
<td>1</td>
</tr>
<tr>
<td>Died</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

Twelve of the sixteen placements, that have left the service, returned home i.e. 75%.

**6.3 UNSUCCESSFUL REFERRALS**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>4</td>
</tr>
<tr>
<td>Females</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

**Source of Unsuccessful Referrals**

<table>
<thead>
<tr>
<th>Source</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ninewells</td>
<td>11</td>
</tr>
<tr>
<td>Stracathro</td>
<td>7</td>
</tr>
<tr>
<td>Arbroath</td>
<td>1</td>
</tr>
<tr>
<td>Forfar</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>
Note: These figures reflect the fact that individuals are less likely to move from a community hospital into this type of provision and reinforce the need for a clear definition as to what constitutes intermediate care and how this sits along side other community resources.

**Reason Referral Unsuccessful**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required long term palliative care</td>
<td>1</td>
</tr>
<tr>
<td>Refusal by patient</td>
<td>6</td>
</tr>
<tr>
<td>Inappropriate referral</td>
<td>7</td>
</tr>
<tr>
<td>Circumstances changed</td>
<td>2</td>
</tr>
<tr>
<td>Speech therapy required</td>
<td>1</td>
</tr>
<tr>
<td>Transferred to hospital</td>
<td>2</td>
</tr>
<tr>
<td>Died</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
</tr>
</tbody>
</table>

It is recommended that additional PAM’s support such as Speech Therapy be available to the scheme on a one off basis to ensure that no individual is declined from the service due to the lack of such services.

**Home address of unsuccessful referrals**

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carnoustie</td>
<td>2</td>
</tr>
<tr>
<td>Monifieth</td>
<td>2</td>
</tr>
<tr>
<td>Birkhill</td>
<td>1</td>
</tr>
<tr>
<td>Montrose</td>
<td>4</td>
</tr>
<tr>
<td>Edzell</td>
<td>2</td>
</tr>
<tr>
<td>Forfar</td>
<td>4</td>
</tr>
<tr>
<td>Kirriemuir</td>
<td>3</td>
</tr>
<tr>
<td>Arbroath</td>
<td>2</td>
</tr>
</tbody>
</table>

**Home address of patients who refused referral**

<table>
<thead>
<tr>
<th>Location</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monifieth</td>
<td>1</td>
</tr>
<tr>
<td>Birkhill</td>
<td>1</td>
</tr>
<tr>
<td>Montrose</td>
<td>2</td>
</tr>
<tr>
<td>Edzell</td>
<td>1</td>
</tr>
<tr>
<td>Arbroath</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
</tr>
</tbody>
</table>

Note: Of the six who declined the service two stated that the Glens were too far from their own home or for relatives to visit.
6.4 OCCUPANCY

The total number of bed days used during the evaluation period was 527. The average length of stay was 31 days.

The total number of bed nights available during the stated period is 1068. This gives an occupancy rate of 50%. However, the occupancy for the period January 2002 to March 2002 is 408/534 days giving an occupancy rate of 76%.

In addition 151 days were occupied by three respite placements. The total occupancy over the evaluation period was 678/1068 giving an occupancy rate of 63.5%.

It is noted that during the first three months of the pilot activity levels were extremely low. In an effort to address this the referral period was extended from Monday to Thursdays to include Friday. The option for referrals during the weekend is not possible as the hospital based co-ordinator is only available during weekdays. In addition there is no medical, AHP or pharmacy available during the weekend. The referral criteria were also broadened to include referrals from orthopaedic wards. Additional training was provided to nursing staff at the Glens. However the evaluation does not indicate that these extensions have resulted in a significant increase in referrals.

6.5 INPUTS

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Total Input (Hrs)</th>
<th>Ave. Input (Hrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>13hrs 45mins</td>
<td>1hrs 5 mins</td>
</tr>
<tr>
<td>OT</td>
<td>21hrs 35mins</td>
<td>1 hr 40 mins</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>47hrs 20mins</td>
<td>3hrs 40 mins</td>
</tr>
<tr>
<td>District Nurse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GP</td>
<td>8hrs 10mins</td>
<td>40 mins</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Note: Information only available on 13 patients)
It is considered that there has been a level of under recording of inputs into the service. The above figures do not include travelling time or time spent planning or attending review meetings.

6.6 EVALUATION QUESTIONNAIRES

Evaluation forms developed by the Clinical Governance Group were used to elicit views from service users and their carers.

Service User Evaluation

9 questionnaires completed via a telephone survey undertaken by the Hospital Co-ordinator.

a) Did you know why you were at the Glens?

7 yes, 1 No, 1 Can’t remember

b) How did you rate the following at the Glens?

<table>
<thead>
<tr>
<th></th>
<th>ED</th>
<th>D</th>
<th>S</th>
<th>VS</th>
<th>ES</th>
<th>Comments (that require action)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td></td>
<td>Not much outlook</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bed too small</td>
</tr>
<tr>
<td>Food</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td></td>
<td>The problem was mine I was waiting for new dentures</td>
</tr>
<tr>
<td>Staff</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td>I thought they were short staffed</td>
</tr>
<tr>
<td>OT/Physios</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td></td>
<td>I felt I was not getting any help</td>
</tr>
<tr>
<td>Social work</td>
<td>1</td>
<td>1</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>The ambulance journey was awful I spent the journey completely in pain</td>
</tr>
</tbody>
</table>


The service users in general reported a high degree of satisfaction with the care they received whilst at the Glens. However concerns were expressed regarding the ambulance transport to the Glens. Further consideration is required to address this issue.

c) Could anything be done to improve the service?

No everything was good
More staff
I shouldn’t have had to change rooms
More physiotherapy
d) What would have happened if you hadn’t gone to the Glens?

Don’t Know 1
Stayed in Hospital 3
Gone Home 2
Gone home but would not have managed 3

Six of the nine residents surveyed were of the opinion that without the Glens they would have either been unable to return home or would have been unable to cope at home.

e) Would you recommend this type of care to a relative/friend?

Yes 9  No 0

All the residents would be happy to recommend the service to other family or friends.

Carer Evaluation

The Hospital Co-ordinator surveyed thirteen carers/relatives via telephone.

a) How did you know about your relative going to the Glens?

Hospital Co-ordinator 7
The Glens 1
Social work 2
Ward Staff 1
Patient 2

b) What did you think of?

<table>
<thead>
<tr>
<th></th>
<th>ED</th>
<th>D</th>
<th>S</th>
<th>VS</th>
<th>ES</th>
<th>Comments (that require action)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td></td>
<td>I didn’t see the staff very much. Nobody kept me informed</td>
</tr>
<tr>
<td><strong>Transport</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>Ambulance Journey took a long time. It seemed to take all day to get there. I’m not aware of any problems</td>
</tr>
<tr>
<td><strong>Accommodation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>9</td>
<td></td>
<td></td>
<td>Excellent</td>
</tr>
</tbody>
</table>


The relatives surveyed expressed a degree of satisfaction with the care provided.

c) Could anything have been done to improve the care/services provided?

No. It was excellent
More staff at the Glens
Staff could have spent more time with my mother
Nursing care could have been better
More staff
My mother dislikes lifts yet she was given a room upstairs
My father required more exercise
More experienced staff
Better communication
No, excellent care
Better communication within Ninewells
No, she was well cared for
No, definitely not
Transport could have been better
No

d) What do you think would have happened if they had not gone to the Glens?

We were afraid that if the hospital couldn't keep her she might die
She would have gone down hill
Would have stayed in hospital.
It would have been a disaster
Would have ended up in hospital and would have eventually died
Would have been sent home and would have fallen – eventually would have died
I don't know
Would have stayed in hospital for considerably longer.
Would have managed at home but the burden would have been on us.
Would have stayed in hospital – would have taken longer to recover.
Would have required nursing care. If she had stayed at Ninewells I think she would have died.
Would have stayed in Hospital.
Would have stayed in hospital and would have taken longer to recover.

The vast majority of relatives surveyed were of the opinion that the service had prevented the need for hospitalisation or longer-term care.

e) Would you recommend this type of care/provision to others?

Yes  13
No   0

All the relatives’ survey would be happy to recommend the service to other family members or friends.

f) Any other comments?

An excellent scheme.
It was so good my father didn’t want to leave.
The scheme definitely helped him in remaining at home.
There was little stimulation at the glens
An excellent stepping-stone form hospital to home.
I was impressed with the regular meetings. My father and the family were allowed our say.
My mother didn’t really improve whilst at the Glens yet she was sent home.
A very good idea.
An excellent initiative.
The remoteness of the Glens makes it difficult to visit.
A relative should be identified as the keys contact point and be part of the team.
A very good project.
The scheme really helped.

5. PERCEPTIONS OF STAFF

Staff involved in the pilot project reported the benefits of the service as:

- Promotes and facilitates effective joint working.
- The homely environment of the care home allows for the development of independence skills.
- Provides seamless care.
- Staff have benefited for being able to develop skills.
- Provides the service user with 24hr care and security.
- Adds to the range of community interventions.
- Introduces an ethos of rehabilitation into the care home setting.
- Promotes rehabilitation.

There is anecdotal evidence that the staff felt they could have coped with service users with greater needs. It is recommended that the extension of the pilot period be used to determine whether a more dependent client group could be cared for within this type of provision. This however may have the effect of reducing the percentage of individuals able to return home but may be able to help more people return home who otherwise would have remained in hospital or have gone to permanent care.

8. SUMMARY OF FINDINGS

- Seventeen individuals have been placed within the Glens over the six-month pilot period.
- Twelve of the seventeen have returned home, three moved to permanent care and one died.
- The total number of bed days used during the evaluation period was 527/1068 days, i.e. 50% occupancy. The average length of stay within the pilot was 31 Days.
- The occupancy for the period 1/01/02 to 31/03/02 was 408/534 days i.e. an occupancy rate of 76%.
• 151 days were occupied by three respite placements. The total occupancy over the evaluation period was 678/1068 i.e. 63%.

• The service users reported a very high degree of satisfaction with the care they received whilst at the Glens. However concerns were expressed regarding the ambulance transport to the Glens.

• Six of the nine service users surveyed were of the opinion that without the Glens they would have either been unable to return home or would have been unable to cope at home.

• The relatives surveyed expressed a high degree of satisfaction with the care provided.

• The vast majority of relatives surveyed were of the opinion that the service had prevented the need for hospitalisation or longer-term care.

• All the service users and relatives surveyed would be happy to recommend the service to other family members or friends.

9. ACTION POINTS

The following areas require action:

• Clearly define the range of service provision that constitutes intermediate care.

• Promote the use of the service from hospitals other than Ninewells.

• Develop promotional material specific to the service.

• Resolve the difficulties relating to transport.

• Develop systems for ensuring the provision of a wider range of AHP support when this is required.

• Obtain the views of the different professional groups involved in the services to add to the evaluation process.

• Develop a specific exit strategy for individuals within the service who are unable to return home.

• The extension to the pilot period should be used to explore the option of providing a service to individuals with greater needs than those currently being cared for.

Monitoring of the usage of the service during the extension to the pilot period should continue.
APPENDIX 3

SERVICE USER’S EVALUATION

INDEPENDENT INTERMEDIATE CARE SCHEME

Date of interview:

Interviewed by:

Name:

Address: Telephone number:

Introduction:

We would like to seek your views on the services you received during your stay as part of the intermediate care scheme. I assure you that any information you provide shall remain confidential. With that in mind I seek permission to include the information received in a customer care report. I would also like to be able to call you in 1 month to evaluate your progress.

- Do you know why you were at the nursing home? **YES** **NO**

  Comments:

- When you were in the nursing home – can you tell me how happy/satisfied you were with the following?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Extremely dissatisfied</td>
<td>Dissatisfied</td>
<td>Satisfied</td>
<td>Very satisfied</td>
<td>Extremely satisfied</td>
</tr>
<tr>
<td>Room Comments:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Comments:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>-------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>Extremely dissatisfied</td>
<td>Dissatisfied</td>
<td>Satisfied</td>
<td>Very satisfied</td>
<td>Extremely satisfied</td>
<td></td>
</tr>
</tbody>
</table>

**Staff in Unit/Care received**

Comments:  

**Rehab Team (OT/Physio)**

Comments:  

**Social Work (Review etc.)**

Comments:  

**Transport**

Comments:  

- Could anything have been done to improve the services provided?

Comments:
• What do you think would have happened to you if you **HAD** not gone to the nursing home as part of the Independent Intermediate Care Scheme?

Comments:

• Would you recommend this type of aftercare to your friends or relatives?  
  YES  NO

• Do you have any other comments?

Comments:

Service User signature: .............................................................................

Manager’s signature: ..................................................................................

Follow up call – 1-month post discharge from Independent Intermediate Care

Comments noted.