Intermediate Care

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Maximising Recovery

Continuum of integrated enabling services
at times of transition
alternatives to hospital admission
early supported discharge
seamless return to independence
delay need for long term care
### Individual is unwell at home

**Contact Single Point of Access**

**Enhanced Intermediate Care**

- At home drawing on support as required from:
  - GP
  - District Nurses
  - Community Rehab
  - Community Pharmacy
  - Home care
  - Third sector
  - Telecare
  - Community Ward
  - Hospital at Home
  - Palliative Care
  - Mental Health team

### If too unwell to be cared for at home but no need for urgent intervention only available in acute hospital step up to Intermediate care in a care home, community hospital or housing with care.

- GP, ANP or Consultant review within 24 hours
- In reach specialist support
- Reablement ethos
- Locality MDT input to plan discharge
- Care at home whenever safe and appropriate

### If too complex to be cared for in a community facility, admit to acute hospital.

- Frailty screen at ED
- Specialist comprehensive interdisciplinary assessment
- Consider discharge trajectory
  - Pull home with IC if safe
  - Pull to specialty bed if required
  - Pull to step down bed early if likely to need longer period of rehabilitation or a community care assessment that cannot be provided at home first
ACE nurse/AHP – initiate CGA

- Needs based, focus on frailty, not age related
- Frail older people further benefit from transfer to specialist bed within 24 hours of admission
- MDT review by ACE nurses & AHPs
- Outcomes – numbers screened, time to CGA (24hrs), time to specialty bed, % D/C home.
**AHPs in Emergency Department**

**WHERE**
- Goal: All Boards within Scotland

**WHAT**
- AHPs within ED Team
- Proactive Screening
- Shared Competencies
- Flexible Service – 7 days
- Rapid Holistic Assessment

**WHY**
- RCOP 2007 – national policy
- 40% discharged from front door
- Bed days saved

Thank you so much for helping me to get home to quickly!

Fantastic and efficient service, especially over the weekend!
FRONT DOOR PATIENTS NUMBERS
OVER 3 SITES

HAIRMYRES
MONKLANDS
WISHAW
FRONT DOOR PATIENTS OUTCOMES OVER 3 SITES

- **68%**: Patients not discharged home following assessment by AHP (3 sites)
- **32%**: Patients discharged home by AHP on assessment
Step Up/Step Down

- Bed based intermediate care may be provided as **step up beds** (admitted from home as an alternative to acute hospital admission) or as **step down** (transfer from acute hospital for people who require additional time and rehabilitation to recover but are unable to have this provided at home).
Provision Across Scotland

Where do you currently provide or commission step-up / step-down beds?

- Independent Care Homes: 43.5%
- Council Care Homes: 65.2%
- Housing with Care: 8.7%
- Community Hospitals: 13.0%
- Other types: 21.7%
Provision Across Scotland

How many step up / down beds do you currently provide or commission?

- Independent Care Homes: 139
- Council Care Homes: 203
- Community Hospitals: 74
- Other: 25
- Housing with Care: 4
## Multi Disciplinary Support

Please tick if the service has dedicated support from:

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<th>Onsite</th>
<th>Inreach</th>
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**Legend**

- **Onsite**
- **Inreach**
Aims NLC Step up/Step down model

- to enable older adults to achieve good outcomes
- to enable specialist assessment to be undertaken outwith the person’s home by a range of professional staff
- to assist with the planning and delivery of care in the community and the prevention of admission to institutional settings
- To provide an opportunity to recover from a period of ill health until such time as they can return home
- to enable focused, time-limited intervention and outcome plans to be developed to enable the person to return to their own homes provide support and advice to carers and offer respite breaks
NLC Provision

Monklands House
- 7 Step up
- 7 Step Down
- 7 Respite

Muirpark
- 7 Step Up
- 7 Step Down
- 7 Respite
Acute Hospital

- Assessment
- CARS
- Short term admission to Care Home
  - Agree expected discharge date
  - Identify intended outcomes
- Review
- Discharge

Community

- Assessment
- LPG
Learning points

• Workforce development – district nurse/geriatrician/HCSW

• Access 7 days

• Integration with CMHT

• Proactive board rounds

• Access to medical records
Enabling Spread

• These services need to have a clearly defined purpose that is congruent with hospital and community based services.

• Step down needs to be a fully integrated part of the patient pathway in hospital.

• Step Up needs to be integrated into admission pathways.

• This form of service needs to have the confidence of hospital teams and clinicians.

• There needs to be further clarity over not just step up / down models but also when it is appropriate for a person to remain in hospital for treatment and rehabilitation.