CÙRAM IS SLÀINTE NAN EILEAN SIAR

WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

INTERMEDIATE CARE

PURPOSE OF REPORT

1. To discuss the options for the development of intermediate care.

COMPETENCE

2. There are no legal matters arising at this stage. The Integrated Care fund will be used to support investment of circa £250,000 required as the annual running costs of a bed-based intermediate care facility in Stornoway. That will involve establishing new posts, which will be taken forward in line with our appointments process. The proposed site for the new service has existing tenants, but we are anticipating the premises will be vacant by April 2017.

SUMMARY

3. The need to develop an effective intermediate care service for the Western Isles is set out in the IJB Strategic plan and was a recommendation of the recent Joint Inspection of Older People's Care.

4. The Proposal set out within the paper was developed by a multi-agency, multi-professional working group. It proposes the development of a bed-based intermediate care facility in Stornoway, with further discussion about intermediate care opportunities in other locality areas.

RECOMMENDATIONS

5. It is recommended that the IJB:
    a. Agrees that £250,000 is invested in a step-up/step-down service in Stornoway, as part of the development of an intermediate care service;
    b. Note that this will migrate in time into any new capacity developed within the context of the Lewis Residential Care Review;
    c. Note that further work is required to assess demand and service options for local intermediate care arrangements in Barra, Uist and Harris.

Ron Culley
Chief Officer, Health and Social Care
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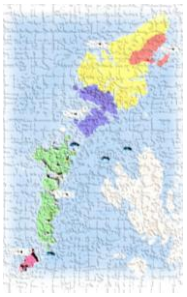

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BACKGROUND

6. Intermediate Care is commonly described as 'the range of services which will help to divert admission to, or support discharge from, an acute care setting through timely therapeutic interventions which aim to divert a physiological crisis or offer recuperative services at or near a person's own home. Intermediate Care is not simply convalescence or an alternative to long stay beds, since these do not have therapeutic input.'

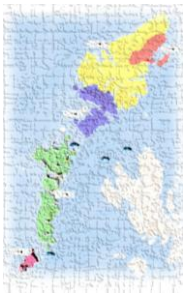
7. There is an emerging evidence base for intermediate care, not least in terms of the King's Fund analysis of new services in England.

8. It is also driven by national policy, with the Scottish Government advocating its development as part of a mixed economy of care and support.

9. The absence of dedicated intermediate capacity was picked up by the Care Inspectorate and Healthcare Improvement Scotland in the Joint Inspection of Older People's Services (2016) and now features in our strategic plan. Within this context, we now need to consider the shape and function of a new intermediate care service, and the development of an organisational culture and training regime which supports a reablement philosophy.

10. In a Western Isles context, development work has been ongoing with the creation of an early supported discharge team, but as can be seen from the diagram below, we still have major service gaps in our approach to reablement: we have yet to fully implement ward-based reablement, to keep people active during a hospital stay; and we have almost a complete absence of community based intermediate care options. Respite care is available to support unpaid carers' health and well-being but the services we provide are not always focused on keeping the cared-for person active. Equally, the initial work of the Early Supported Discharge team has been positive although arguably now needs to expand.

11. Our strategic plan sets out our ambition to deliver a bed based capacity and home based service, and our intermediate care service needs to be able to provide these options. In addition, we have also identified a need for a rapid response team, following the redesign of the Mobile Overnight Support Service. Reablement in ward settings is being progressed through the delayed discharge action plan.



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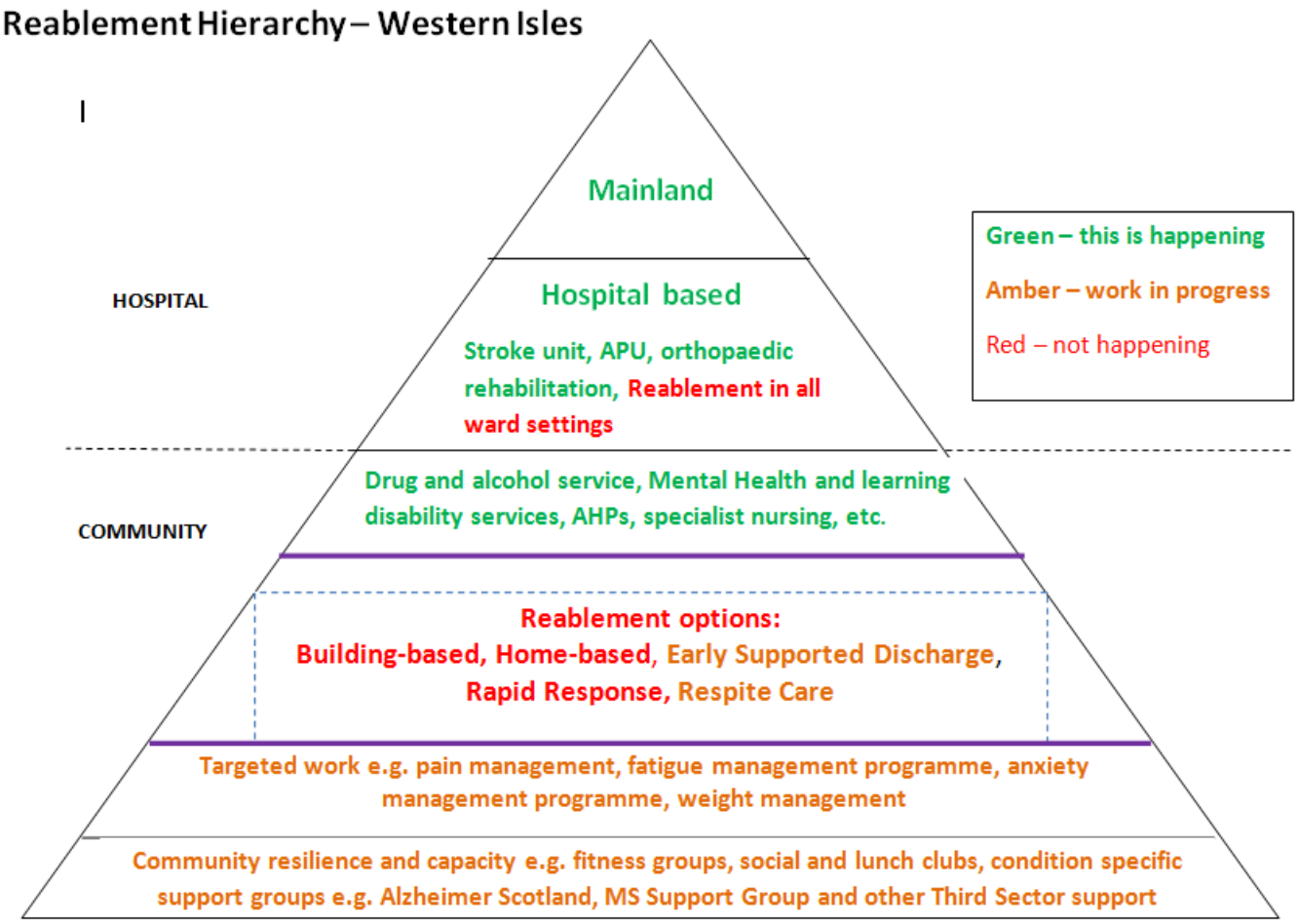
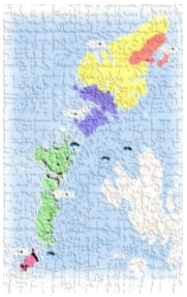


SERVICE DEVELOPMENT

12. Looking ahead, the Early Supported Discharge team has the potential to evolve into a broader Intermediate Care Team, which would be the bedrock of an intermediate care service spanning across the Erisort ward of the Western Isles Hospital, a community based step-up/step-down facility and home based reablement. It would function as a multi-disciplinary team, providing the core coordinative and specialist input required to drive the entire system towards a reablement and assets based approach and the delivery of an intermediate care service on a 24/7 basis. The initial team of an occupational therapist and a nurse would need to be supported by a wider complement of staff, including home care supervisors and rehabilitation assistants. The team could then provide coordination and specialist input across three care venues: the Western Isles hospital, a step-up/step down intermediate care facility (for those unable to return home immediately) and service users' own homes. The team would link into mainstream health and social care resources, including GPs, physicians, community nursing, social care, and AHPs. Our third sector partners would also have an important contribution to offer.



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13. The further development of an Intermediate Care team would be taken forward in parallel with the structural integration of Community Nursing and Home Care, coinciding with the training of staff to incorporate reablement skills and practices that should be included within the development of any model. This would seek to capitalise on the Stornoway and Broadbay contracted homecare workforce and move progressively into the other localities. We should continue to work on an assumption about getting people back to their own homes as soon as possible to optimise rehabilitation.

14. The Intermediate Care Service would also need to connect to our emerging vision around the development of a rapid response team, situated in the emergency department. This is still being developed, but in outline terms we are interested in developing a blended team of social care workers/healthcare assistants alongside Community Unscheduled Care Nurses to give us rapid response capability.

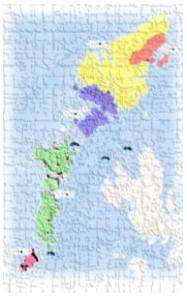
KEITH STREET INTERMEDIATE CARE SERVICE

15. It is proposed that a bed-based intermediate care service should be created in the soon-to-be vacant HHP premises on Keith Street, Stornoway. The model is based on the following operating assumptions:

    - Service aimed at people who can be supported to recover functional independence but for whom a return home is not possible in the short term.
    - Service capacity: 4 beds supporting step-up from Lewis and Harris; and step-down from the Western Isles Hospital/mainland
    - Operating hours: the service would be provided on a 24/7 basis, with therapeutic interventions delivered during the day.
    - Staffing complement: 4.6 x FTE Social Care Worker (around 12 staff members) on a 1:4 ratio of staff to service user. Intermediate Care Team provides and coordinates specialist therapeutic intervention.
    - GPs would provide medical oversight, as required.

16. The basic cost of the service would be as follows:

Annual Cost	**£**
Staffing	188,530
Rent	3,640
Provision	6,000
Repair and Maintenance	3,000
Utilities	1,100
Council Tax	1,150
Telephones	750
Total	**204,170**



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17. While the social care worker role would span a range of tasks from care coordination and rehabilitation support to personal care, it would be augmented by a range of additional specialists within the Intermediate Care Team. This includes the development of two rehabilitation support workers, who could work across care venues, including in the Keith Street property. Further work is required to detail how this would connect with mainstream OT and physiotherapy, as well as discussion about what equipment would be required within a new unit.

18. Further work is required to examine short-medium term intermediate care requirement dedicated to Harris, Uist and Barra.

SERVICE OPTIONS – MEDIUM TERM

19. Our plan should be to build on this early test of change by implementing core intermediate capacity across other localities, following demand assessments. There are a number of medium term developments that we will look to take forward:

    i.) Developing bespoke intermediate care support within the proposed extra care housing units in Stornoway/Westside (circa 2020)
    ii.) Development of bespoke intermediate care within the context of mental health redesign, which might include looking at third sector step-up/down support for people with acute mental health conditions
    iii.) Development of a bespoke intermediate bed within redesigned Uist and Barra hospital (circa 2020)
    iv.) Development of a bespoke intermediate bed within new St Brendan's extra care unit (circa 2020)

CONCLUSION

20. The absence of dedicated intermediate capacity was picked up by the Care Inspectorate and Healthcare Improvement Scotland in the Joint Inspection of Older People's Services (2016) and now features in our strategic plan. Within this context, we now need to consider the shape and function of a new intermediate care service, and the development of an organisational culture and training regime which supports a reablement philosophy.

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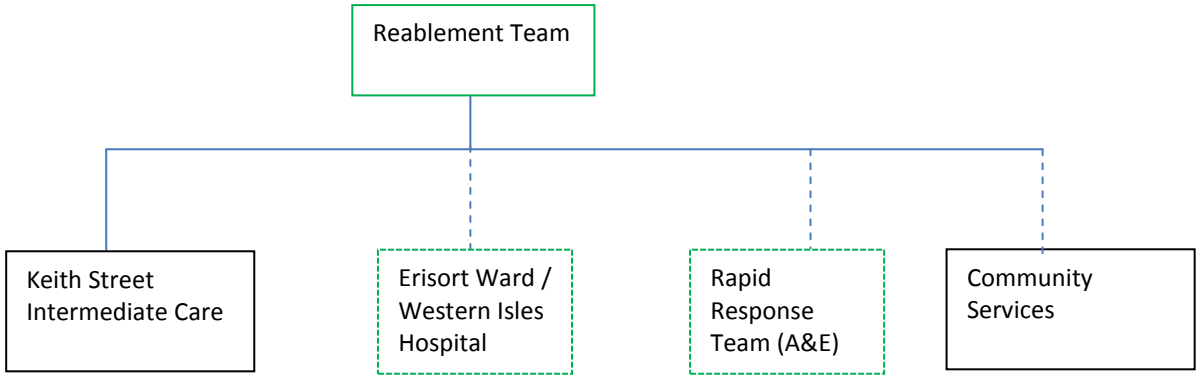
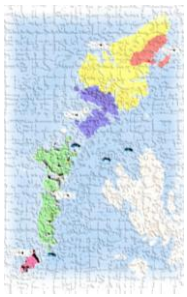
Intermediate Care Model

Service	Initial Capacity	Investment (£)	Source
Intermediate Care Team	1 x FTE nurse 1 x FTE OT 2 x FTE Care and Support Supervisors (Grade F) 2 x FTE Rehabilitation Assistants (Band 3)	In post In post 65,000 49,300	 Homecare Redesign Integrated Care Fund
Keith Street Intermediate Care	4.6 x FTE Social Care Workers (Grade E) (around 12 staff members) providing 24/7 care on a 1:4 ratio of staff to service user	204,000	Integrated Care Fund
Erisort Ward/Western Isles Hospital	Existing capacity, with a view towards building community capacity over time	0	
Emergency Response Team	24/7 MDT based in Emergency Dept. involving existing Emergency Dept. staff, Community Unscheduled Care Nurses and additional healthcare support workers (Band 3)	85,000	MOSS redesign





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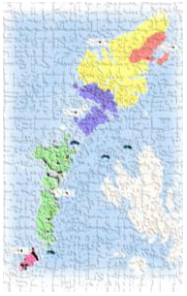

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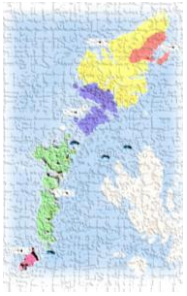

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