Intermediate Care Report Summary

For The Provision Change Board

East Lothian
Health & Social Care Partnership

Contents

Background

This paper provides a summary position on the intermediate care work stream of the Capacity and Planning working group, chaired by Iain Gorman, Head of Operations. This working group was formed to support the Community Hospitals and Care Homes Provision Change Board.

It explains what intermediate care is and what services we already have in East Lothian. Intermediate care has a wide definition of use. It is not new. Many areas have provided these services for many years including East Lothian.

The intermediate care services in East Lothian have helped contributed towards us having the lowest proportion of delayed discharges compared to other local health and social care partnerships. The investment in these in previous years has been beneficial over longer term. We believe intermediate care is one of the best investment opportunities for the partnership now and in future years.

					Age			
Local authority of residence[1]	Total Population (June 2020)	Delayed discharge bed days 2020/21	Delayed discharge as % of total population	Average daily number of beds occupied 2020/21	Delayed discharge bed days 2020/21: ages 18 to 74	% of total	Delayed discharge bed days 2020/21: age 75+	% of total
City of Edinburgh	527620	32798	6.22%	90	11683	36%	21115	64%
East Lothian	107900	3935	3.65%	11	1346	34%	2589	66%
Midlothian	93150	7150	7.68%	20	2157	30%	4993	70%
Scottish Borders	115240	10217	8.87%	28	2634	26%	7583	74%
West Lothian	183820	7381	4.02%	20	2689	36%	4692	64%

Source: All data sourced from Public Health Scotland (2020/21) Scottish Care Home Census 2021

Strategic Direction

The East Lothian **IJB Strategic plan**[1] commitment is to support people closer to home, in their own home or in a homely setting. This will be achieved through a number of measures resulting from re-modelling services as well as the services we commission. The development of intermediate care services is a key strand of this objective.

Health and Social Care Delivery Plan 2016 Scottish Governments delivery plan[2] sets out the framework and actions needed to ensure that our health and social care services are fit to meet

[1] 2019-2022 East Lothian IJB Strategic Plan (currently being updated)
[2] Scottish Government: Health and Social Care Delivery Plan (Dec 2016)

requirements. The plan links to our focus for intermediate care and Home First approach and to "*ensure people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission*".

More recently the Scottish Governments **Older People's Health and Social Care statement of intent**[3] set out the approach (a new national strategy) to older people's health and social care in Scotland, taking account of Covid on older people and whom were affected worse by the virus. This work has the basis of Building on the **Foundation of the A Fairer Scotland for Older People**[4], which envisions everyone being able to live independently, driving the decisions about their own health and wellbeing.

Living independently, living in their own homes is a theme appearing across many national policies and in the original Shifting the Balance of Care[5] strategy direction by rebalancing the model of care from bed base to community provision.

"We want older people in Scotland to enjoy full and positive lives in homes that meet their needs" is a goal of the ***Age, Home and Community in 2018 (revised from 2011)*[6]**.

This will take a person centred approach to achieving the aim of older people enjoying full and positive lives, in a home that meets their needs. This allows individuals to have their say about what they want from their home; the size, location, community, technology, access to transport and the many individual requests that make their home ideal for them.

The ***Older People's Health and Social Care statement of intent*** (2021) focuses upon 4 areas to support its vision.

1. **Prevention**: Staying physically and mentally active can make people more resilient as they age, reducing risks of dementia, widening social circles and helping prevent falls.
2. **Home First**: approach to ensure we deliver care and treatment in peoples own homes and local communities.
3. **Integrated health and social care**: Supporting people to age well and live well requires a multidisciplinary or even multiagency response.
4. **Dignity and respect at end of Life**: When people require end of life care, they must have access to high quality care, focussing on the physical, social, psychological and spiritual dimensions of care.

Enabling this is the way we develop and deliver our integrated health and social care services to support people to live well and independently in their own communities. The Independent Review of Adult Social Care[7] and the development of the National Care Service will influence the way in which services can be developed.

[3] 2021 Scottish Government Older People's Health and Social Care statement of intent
[4] 2019 Scottish Government
[5] 2009 Improving outcomes by Shifting the Balance of care Shifting the Balance of care delivery group
[6] 2018 Age, Home and Community: next phase
[7] 2021 Independent Review of Adult Social Care in Scotland (*sometimes short hand as The Feeley Report*)

The work we are doing within the Provision Change Board and in our future actions and objectives around intermediate care supports the direction of the Scottish Governments Older Peoples statement of intent.

This paper is not providing specific recommendations. It is produced to help support the communication and engagement sessions and wider discussions over the summer period to have discussions with the public and to gather their thoughts, views, challenges, ideas or proposals on how we can develop further the intermediate care provision across East Lothian. And in the next stage of this work with local areas, residents, local groups to develop these models and provision across the County.

What is Intermediate Care?

What is Intermediate Care.

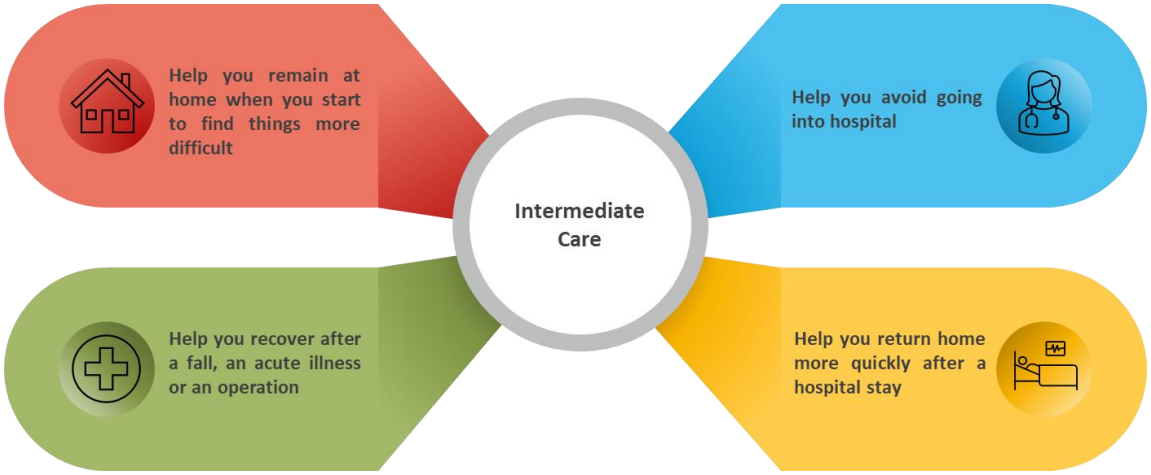
There are many definitions used. At its simplest, intermediate care services are those health and social care services that prevent people needing to go in to hospital or getting them home from hospital more quickly. Home First, reablement, rehabilitation and intermediate care are terms we also use and they all represent different aspects of intermediate care.

The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GP's, and social care.

The Scottish Governments *National Intermediate Care Framework* document (2012)[8] describes it as "maximising recovery and promoting independence".

The National Institute for Health and Care Excellence suggest "Intermediate care services help people recover, regain independence and remain at home." (NICE[9]) and show in diagram 1.

Diagram 1. The Four Key Principles of Intermediate Care from the NICE Guidelines, 2018



This definition links clearly to our Home First approach and the goals of, people being cared for at home (or as close to home as possible). Secondly, preventing avoidable admissions to hospital and thirdly, where hospital admission is necessary, Home First seeks to support timely discharge.

[8] 2012 Scottish Government Maximising Recovery, Promoting Independence: an intermediate care framework for Scotland.
[9] 2018 National Institute for Health and Care Excellence

What type of services are intermediate care.
Intermediate Care encompasses a range of functions which focus on **prevention**, **rehabilitation**, **reablement** and **recovery**, depending on the needs of the individual. These may be provided through Bed based services (in our community hospitals and care homes), Community based services (providing assessment and intervention in peoples own homes, Crisis response (such as Emergency Care and Falls services), and reablement and rehabilitation (e.g. Hospital to Home and East Lothian Rehabilitation service).

How is intermediate care delivered.
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care will depend on a person's needs at that time.

What are the aims of intermediate care.
There are three main aims of intermediate care and they are to: -

1. Help people avoid going into hospital unnecessarily.
2. Help people be as independent as possible after a stay in hospital; and
3. Prevent people from having to move into a care home until they really need to.

We need it to prevent unnecessary acute hospital admission, help support quick and appropriate discharge. It promotes faster recovery from illness and support anticipatory care planning and helping people to self-manage their long term conditions.

It is clear the key demographic changes taking place in Scotland and East Lothian.

- Over 65yrs population - increases by 63% by 2035
- Over 75yrs population - increases by 82% by 2035
- Over 85yrs population - increases by 147% by 2035

In East Lothian[10]:

Age Group	2020-2030	% change	2020-2043	% change
0 to 14	-693	-3.8%	-474	-2.6%
15 to 24	1,156	10.5%	432	3.9%
25 to 44	1,954	7.9%	1,458	5.9%
45 to 64	-1,338	-4.3%	2,204	7.1%
65 to 74	3,118	25.8%	2,303	19.0%
75 to 84	2,397	32.7%	5,846	79.8%
85+	741	28.2%	2,540	96.8%
Total	7,335	6.8%	14,309	13.3%

[10] Source: NRS 2018 based principal population projections for Council areas

The health and social care system faces major challenges, ever tighter budgets, rising demand, increasing and inflationary costs. Levels of hospital activity have also continued to rise over recent years. The impact of Covid-19 continues and will do for a considerable period. These pressures will be intensified by demography shown above.

The work to date indicates that we do not require additional community hospital bed capacity in the short to medium term in East Lothian but we will need to continue to monitor this. Care Home beds require replacement due to the fabric and condition of some of the HSCP-owned stock. Developing intermediate care will be a key focus.

Key variations between different parts of the country showed[11] :

- Emergency hospital admissions of people aged 75 and over varies
- Hospital admission of people aged 75 and over from residential care/ nursing homes varies 604-fold
- Admissions to residential care and nursing home of people funded by councils varies six-fold
- The number of people still at home 91 days after being discharged from hospital to a reablement/rehabilitation service varies nine-fold.

The National Audit of Intermediate care (2015) highlighted that Reablement capacity was actually falling – despite increasing evidence of its effectiveness – and waiting times for intermediate care are rising. We know this locally with the need to identify capacity, staffing and resource to provide additional packages of care and reablement care, occupational and physiotherapy in the community.

Evidence shows that well-designed intermediate care can[12]:

- improve people's outcomes and levels of satisfaction
- reduce admissions to hospital and long term social care services
- reduce delayed discharges.

The national audit of intermediate care also **noted positive outcomes** from the use of intermediate care provision:

92% of people who used home-based or reablement services maintained or improved their dependency score (a measure of the help they need with activities of daily living).

93% of people who used bed based services maintained or improved their dependency score.

70% of people who received intermediate care following a hospital stay, were able to return to their own home.

[11] 2015 National Audit of Intermediate Care Summary Report (England)
[12] 2015 National Audit of Intermediate Care Summary Report

72% of people did not move to a more dependent care setting.

88% of people using health based intermediate care services meet their goals (wholly or partially).

90% of people said they were treated with dignity and respect.

These are positive patient outcomes from the use of intermediate care provision.

Intermediate Care services in East Lothian

Intermediate Care services in East Lothian

Set out below are a list of some of the Intermediate care services that we have in East Lothian, with a description of what they do and what their goal is.

East Lothian Rehabilitation services (ELRS)

Intermediate Care provides intensive short-term interventions that are goal and outcome focused. The professionals have a strong rehabilitation ethos, are positive risk takers and work collaboratively with patients and citizens to agree person-centered goals.
The East Lothian Rehabilitation Service (ELRS) already provide many services which fit within this model of care and are well suited to develop to further provide Intermediate Care within the East Lothian Health and Social Care Partnership (ELHSCP).

Community Advanced Physiotherapy Practitioner

The role of the Community Advanced Physiotherapy Practitioner (APP) was established within ELRS in March 2020 with the remit of developing a pathway for the management of patients with Long Term conditions in East Lothian.

Shortly after this, the emergence of COVID shifted the primary focus of the team to the establishment of a Respiratory Pathway within East Lothian, supporting the pan-Lothian response to COVID and the management of high-risk chronic respiratory patients.

Within the 3 geographical clusters (based in Dunbar, Haddington, and Musselburgh) the APPs provide highly specialist assessment and intervention, including nebuliser trials and oxygen weans and liaise closely with both Primary and Secondary care to optimise the patient pathway and clinical care. In contrast to traditional Community Respiratory Teams, input from the APP's is open to patients with all long-term respiratory conditions. Referrals are received from the acute for supported discharges' and optimisation of current care/self-management. Additionally, referrals are accepted from GP's for Prevention of Admissions (POA) Admission's, self-management support and long COVID input. Individuals seen by APPs are able to directly self-refer into the service at any time in the future should their condition change or deteriorate.

The APPs are an essential role within an Intermediate Care model to provide specialist community input and support this patient group to avoid unnecessary hospital admissions and maintain optimum physical and mental wellbeing

Community Advanced Practice Occupational Therapist (APOT)
The role of the Community Advanced Practice Occupational Therapist (APOT) was established within ELRS as a test of change in July 2021 for 1 year, to develop a pathway of early intervention for those with long term conditions. Given the rising ageing population in East Lothian, the decision was made to focus on those considered 'frail' displaying multiple co-morbidities. Reflecting the interface with primary care, the pathway was developed in collaboration with a GP in Dunbar Medical Practice, tested and rolled out across our east cluster. This includes 6 GP practices: 3 in Dunbar, East Linton, Gullane and North Berwick.

With the backdrop of wider service pressures on capacity, this post holder has also been utilised to respond to core cluster work of Discharge to Assess (D2A), Hospital@Home (H@H) and Prevention of Admission (POA) referrals, significantly reducing time available to work with the GP practices on the new pathway. There has also been an urgent need to address the increasing number of referrals taken from the SafeHome OT pathway from A&E. With the broader Occupational Therapy and Physiotherapy community clusters struggling to respond jointly, the decision was taken to utilise the advanced clinical reasoning and decision-making skills of the APOT. This has had the positive impact of saving clinical hours within the cluster.

Alongside establishing this pathway with the frail population, the need to address post-COVID referrals within ELRS became evident. The APOT resource has therefore also been utilised to triage, assess, and provide intervention to post-COVID referrals.

The development of the APOTs is important within an Intermediate Care model to provide specialist community input and support to this patient group to avoid unnecessary hospital admissions, support early discharge including from A&E and to maintain optimum physical and mental wellbeing of this patient group.

Community Physiotherapy and Occupational Therapy team
The Community Physiotherapy and Occupational Therapy team support several unscheduled care pathways including Discharge to Assess (D2A), Hospital@Home (H@H) and Prevention of Admission (POA).

- Discharge to assess: Appropriate for patients with ongoing therapy assessment and rehabilitation needs to facilitate timely discharge from hospital. Assessment takes place on day of discharge or following day as agreed between referrer and accepting clinician.

- Prevention of admission: Suitable for patients in the community with an acute decline in mobility and function, requiring urgent assessment of transfers and mobility, where equipment provision and support in accessing emergency care (as required) could prevent a hospital admission. These patients should have had a medical review within 24hrs of referral to rule out new medical issues that require attention

The team provide comprehensive assessment and rehabilitation to patients in their own homes to improve independence and reduce requirements for care. In addition, the Community Physiotherapy team (Domi Physiotherapy) provides scheduled care in the form of assessment and rehabilitation to patients referred into the service either by a health professional or through the self-referral phone line. This team is based across three local hubs in Belhaven Hospital, Musselburgh Primary Care Centre, and East Lothian Community Hospital (ELCH).

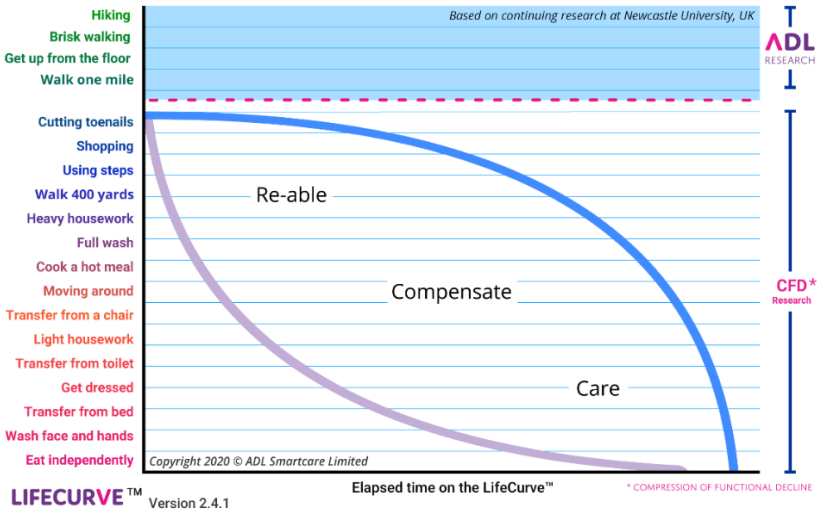
This team already provides the key elements of Intermediate Care and furthermore completed a successful Test of Change in 2021 looking at enhanced D2A model to provide rehabilitation focused short term care. The project was able to evidence a saving of an average of 11 days per patient with subsequent cost saving of £3,300. In addition, 68% of patients during the Test of Change had a reduction in their care package on completion on their rehabilitation.

East Lothian Rehabilitation service Digital platform

In March 2022 ELRS launched a new digital platform ***Access to a Better Life in East Lothian*** https://abetterlife.eastlothian.gov.uk. It provides information and tools to support people to manage their own health and wellbeing, and to be a resource if they care for others. The new platform provides a one stop access point for information on the LifeCurve, support on self-management and how to contact and refer into the ELRS. The platform is interactive with an interactive Body Map and Smart House.

The **LifeCurve model** below shows the paths that may happen for an individual and how with reablement, rehabilitation or other support this trajectory could be changed more positively**.** Research shows that if people can act early, they can have the greatest impact on their ageing journey. Most people will start to lose the ability to carry out some daily tasks and if people are able to keep their abilities for the longest possible time at the early stages in this decline, they will have the best ageing journey.

The most recent ADL INSIGHTS report shows encouraging progress on the development of the digital platform and a report is attached for reference. It covers the period February 2021 – to February 2022 with the latest platform being launched in March 2022.



ELRS has identified the following LifeCurve Insight Projects:

1. Enhanced Discharge to Assess – Completed
2. Pain Management
3. Frailty – APOT
4. Leisure Services in collaboration with Enjoy Leisure
5. Falls Pathway
6. Online Rehabilitation Platform
7. Volunteer Centre of East Lothian
8. Community Care Worker led early intervention and supported self-management clinics
9. Digital platform development

The digital platform is an important element of an Intermediate Care model to ensure individuals access the right support at the right time to promote early intervention and self-management and subsequently optimum aging. It also helps East Lothian HSCP receive direct feedback on what is important to people who have accessed the platform.

East Lothian Community Occupational therapy

The Community Occupational Therapy team in East Lothian provide a wide range of interventions. There is a *Single Point of Contact Telephone Service* where professionals, clients or carers can telephone to seek advice on solutions or discuss requesting Occupational Therapy intervention. An *assets-based approach* is utilised at this first point of contact to determine whether some people can self-manage and look at opportunities to improve function through exercise programmes, signpost to the *Access to a Better Life in East Lothian* website or self-purchase equipment which may meet their needs. Once these options have been explored if a person needs an assessment, the person

will be prioritised and either allocate immediately to an Occupational Therapist or placed on the waiting list for assessment.

The Person Environment Occupation Performance Model (PEOP) is utilised during assessment which allows assessment of how a person's Occupational Performance is shaped by interactions between the person, environment, and occupation. Following this assessment, the team discuss solutions and opportunities to the areas of need identified. These will initially be in the form of rehabilitation and equipment to stabilise a situation if this is needed. Should a person still be unable to manage their Occupational performance tasks longer term equipment and adaptations to keep them as independent as possible will be pursued.

At this point the team will transfer a persons' Occupational Therapy needs onto the Occupational Therapy specialist services to look at design aspects of their environment, identify higher spec equipment needs e.g. postural management and enhanced Moving and handling tasks for those further down the LifeCurve with no rehabilitation potential.

The East Lothian Council Community Occupational Therapy team provide essential interventions within an Intermediate Care model to provide specialist assessment and interventions to support people to live independently at home for longer

East Lothian Council Community Occupational Therapy Complex Cases and Adaptations
The Complex Cases and Adaptations part of the Community Occupational Therapy service was established in June 2021. The service areas comprise: major adaptations to owner occupied properties; complex cases and equipment; children's equipment and adaptations; Access Officer (Occupational Therapist in Education); statutory reviews and assessments in care homes, and care assessment and reviews.

Although most of these roles were previously met by Community Occupational Therapists, it was recognised that some areas of assessment and provision are specialist and complex and if these tasks are not carried out regularly within case working, that the time taken to complete tasks is considerably greater. Therefore, to have a team with specialist knowledge for those accessing assistance and colleagues who may need support in any of the areas highlighted would be beneficial.

Most recently, the team has been able to support the assessment of moving and handling in response to the care crisis. Three Occupational Therapists are now in post to complete functional assessments, particularly in relation to whether rehab can achieve improvement and if not, to provide an observed assessment of functional ability to make accurate recommendations for care.

Several of the team have recently completed moving and handling **train the trainer** training which means staff can train informal carers in moving and handling tasks when appropriate. This is of particular benefit if there are gaps in care that can be bridged by family members.

The service is also developing links with the tissue viability service and the care home teams to complete joint training and assessment to improve the outcomes of some of the most vulnerable in our community.

By enabling properties to be adapted and providing specialist advice and intervention in terms of moving and handling and postural management, this enables people to remain at home for longer in line with the Intermediate Care model.

Falls

Pre COVID, East Lothian Rehabilitation Service ran a falls prevention programme entitled 'Steady On.' This mainly took the form of a 12-week programme of Otago Strength and Balance classes, with an additional education component. Patients who had had a fall, were identified as at risk of falling or had a fear of falling were eligible for referral into the service. Unfortunately, due to the COVID pandemic in March 2020, all 'Steady On' programmes were discontinued. Initially any patients who were in the middle of a programme were supported remotely where possible, via telephone consultations and posted resources/signposted to online resources.

With regards to falls in general, there has been significant work into the area of Falls Prevention and Management in Scotland[13], with well published National Guidelines and Frameworks, and the requirement that falls are now a National indicator that every Health and Social Care Partnership must report on annually. Following a review of falls East Lothian wide, it was acknowledged that an integrated Falls Pathway was absent. As a result, a Falls Project Manager post was created, with the remit of completing an extensive mapping of all falls services currently provided across East Lothian and producing a detailed recommendation report on the development of a falls framework and pathway for East Lothian Health & Social Care Partnership. This was completed in May 2022. The paper was ratified and approved by ELHSCP Transformation Board: TEC, and is due to be taken to ELHSCP Strategic Planning Group in October 2022.and Social Care Partnership.

Inpatient Occupational (OT) and Physiotherapy (PT)

The Occupational Therapy and Physiotherapy service provides assessment and intervention to 88 inpatient beds over 4 wards at ELCH; wards 3 and 4 which are predominately assessment and rehabilitation wards and wards 5 and 6 have a step-down remit. Wards 5 and 6 were established on an interim basis due to covid-19 and in due course this additional capacity will retract back to wards 1-4 being available.

Therapy intervention is predominately one to one, with additional therapeutic groups provided as required including a Breakfast Group, Exercise Group and Destination Home Group. Group provision has been limited due to COVID restrictions and limited staff capacity. The patient cohort covered is over 65's and includes Medicine of the Elderly, stroke, orthopaedics and general medical patients. Therapy staff provide a rehab focused approach to all interventions and are a key part of successful discharge planning, including provision of equipment, Technology Enabled Care (TEC), assess for care and onward referral for ongoing input in the community.

Current patient cohorts have changed in profile over the last 3 years and have become more complex with higher clinical/care needs and multifaceted causes. Our developing pathways have

[13] 2019 Falls and Fracture Prevention Strategy for Scotland, 2019-2024, 2014 The Prevention and Management of Falls in the Community

enabled more straight-forward patients to be discharged directly from the acute into community care, without a requirement for hospital-based rehab.

Mental Health provision

The Mental Health Physiotherapy team provides Physiotherapy input to patients who require ongoing input from other Mental Health Professionals. This input is provided in a variety of settings across Lothian including Inpatient, Outpatient, Domiciliary and Exercise Therapy Groups. The team uses physical approaches to promote, maintain and restore physical, psychological and social wellbeing. The aim is to promote physical health to enable improvement in mental health and wellbeing. A person centred approach is used, with the best available scientific and clinical evidence followed. Treatment options provided include rehabilitation, exercise provision and support, promotion of functional movement and health promotion.

Musculoskeletal (MSK) Physiotherapy including Advanced Practice Physiotherapy and Exercises Specialists

The Musculoskeletal Physiotherapy Service provide several work streams including the MSK Advice Line, which allows timely access to physiotherapy assessment and intervention. Staffed by a team of Advanced Physiotherapy Practitioners (APPs) an individual will receive a call within two working days of contacting the service to allow for early identification of any sign's serious pathology, offer brief assessment, and advice. The APP can then organise any follow up required in a timescale appropriate for the complaint the individual is presenting with.

The core MSK team deliver specialist rehabilitation to those complaining of MSK conditions. They provide education, rehabilitation, self-management strategies and are actively involved in screening to determine any opportunities for prevention or early intervention e.g. early fall presentations being seen in MSK services with an injury as a result of a fall.

Exercise Specialists are a vital part of this team helping support individuals into longer term management plans and to self-manage within community settings such as local gyms.

The MSK service is an important part of an Intermediate Care model, to optimise early and effective rehabilitation and support self-management of conditions.

This service was established as an interim at Edington Hospital whilst the bed capacity transferred to East Lothian Community Hospital. It has been well received with over 770 attendances at the clinics.

Neurology Outpatient Physiotherapy

East Lothian Rehabilitation Service provides an unfunded neurology outpatient physiotherapy service which includes exercises specialists. This service provides essential early intervention and rehabilitation to patients with neurological conditions. Enhancing patients understanding of their conditions, importance of appropriate self-management strategies and a knowledge of when and where to request further assistance. This input supports citizens to maintain the right path on the LifeCurve.

Multi-disciplinary team (MDT) neurology pathway funding bids in 2021 and 2022 have both been unsuccessful. A neurology outpatient service is an important element of an Intermediate Care model to support early intervention, prevention, and self-management.

Pain Management

The East Lothian Physiotherapy Led Pain Management Service (ELPMS) was established within East Lothian Rehabilitation Service in September 2020, to provide specialist pain management support for individuals living with persistent pain across East Lothian. The service is the first and only service in Lothian to utilise the expertise of Exercise Specialists in supporting patients living with persistent pain. Referrals are received from all health professionals including allied health professionals (AHPs), GPs and Pain Consultants.

The aims of the service are to:

- Reduce the effect pain is having on an individual's quality of life through teaching ways of self-managing and coping with persistent pain
- Improve the individual's ability and confidence to self-manage pain associated disability
- Reduce reliance on health care resources.
- Reduce presentation with pain related issues to primary care.
- Promote sustainable behaviour change /change unhelpful beliefs and ways of thinking which contribute to disability.
- Improve participation in daily activities.
- Improve quality of life through changes in physical fitness, strength, endurance, and flexibility.

To achieve these aims, ELPMS delivers group and one to one pain management sessions in response to individual need. During the pandemic, the ELPMS was the first in Lothian to utilise technology to deliver live, online pain management group services through the NHS Scotland CISCO Video Conferencing System, with over 120 digital appointments offered.

Group sessions continue to be delivered both face to face and digitally in response to patient need, optimising access to pain services across a wide geographical area. The service promotes long term sustainable behavioural change through onward referral to the East Lothian Fundamental Rehabilitation and PACE exercise programs.

To optimise quality of life and meet the often complex needs of the individual, ELPMS collaborate with the multidisciplinary services within the Health and Social Care Partnership, with onward referral to Community Mental Health services, Pain Psychology (Lothian Chronic Pain Service, AAH), Pain Clinic and Domiciliary therapy services.

The team actively support the wider clinical teams through the delivery of Level II Pain Training, In-reach to GP practices and providing peer support in the management of complex persistent pain presentations.

Over the past year since the service began in October 2020, demand for East Lothian Pain Management services has increased and it is an important part of an Intermediate Care model to support appropriate intervention for this patient group.

Single Point of Contact Phoneline

ELRS established a single point of contact phoneline system utilising the BT Cloud Contact platform in June 2021. This has enabled citizens to contact the service through one central system and speak to the right professional at the right time. This allows for self-referral and supports self-management. To date there are five services that are within this system already, with plans to further increase this. Current services included are:

- Patient focused booking (PFB)
- Musculoskeletal (MSK)
- Request for Assistance Occupational Therapy (R4A)
- Community Physiotherapy and Occupational Therapy (APP)
- Enquiry line (Enquiry)

The individual contacting the phone line will speak to a member of the administrative team if calling the PFB / MSK / Enquiry line. A message will be passed to the appropriate clinical team and a senior clinician will contact the patient directly within two working days hours to complete a telephone assessment if required. The individual will speak directly to a senior clinician on the R4A and APP line who are able to provide relevant information or complete a referral.

This service already has good analytics, to report volume of work and several subsequent variables. For example, the volume of calls per GP Practice and the outcome of calls.

This phone line is an important element of an Intermediate Care model to ensure the population of East Lothian have one phone line to contact all services, promoting self-management and reduced GP appointment.

Technology Enabled Care (TEC)

ELRS recognise the value of using TEC (Technology Enabled Care) to help people remain as active, independent, enabled and as safe as possible key principles within an Intermediate Care model. TEC has been identified as the Golden Thread running through all services within ELHSCP due to the improved outcomes it creates for patients, carers and staff. When used at the right time it can aid prevention of admission, facilitate hospital discharge, and enable carers to continue to look after their loved one. TEC can also be used as an alternative to, or alongside care provision, reducing demand on this scarce resource. TEC is cost effective and plays a key role as an enabler in modernising health and social care. The TEC team meets the key principles of an Intermediate Care model.

The TEC (telecare) team, compromises of 4 TEC officers, 1 manager and admin support. In addition, there is 1 Occupational Therapist (0.6WTE) and TEC Officer (0.6WTE) to provide Smart TEC

intervention. The telecare team provide a range of telecare equipment to support individuals including community alarms and pendants, devices to help detect a fall and environmental sensors to help protect the person in their own home such as fire safety. The TEC team provide essential training in TEC awareness to ELHSCP and Housing staff to inform and upskill the workforce to ensure a TEC first approach is considered. The Smart TEC team also provided outcome focused Occupational Therapy interventions at either Wellwynd hub, via phone call or home visit.

ELRS in May 2020 purchased three Alcuris Memohubs which are lifestyle monitoring kits including smart plugs. The team have positive case studies where including Alcuris Memohubs in an individual's home resulted in a reduction in care required. In one case this resulted in a saving of 14 hours care.

Hospital to home team

Provides packages of care in the community. The service is led by the Senior Charge Nurse with full time band 3 carers and registered nursing staff.

A re-ablement model is used which leads to a reduction in the need for care through time, at times stopping the package of care altogether. By using this approach it maximises, maintains and can improve a person's independence by empowering them to return to the activities of daily living and maintaining their independence. Some key benefits of this service is set out below:

- Review of patients, no less than weekly, which prevented re-admission and influenced a change to some of care packages.
- For some patients their care package were increased by one visit which allowed the patient to remain in their own home, where as several other care packages were reduced, due to an improvement of the patients' abilities.
- Patient care is managed efficiently and effectively through integrated team work and enhanced improved communication between both Health and Social care.
- Maintain and deliver high standards of quality holistic care by implementing a flexible person centred approach, based on patient needs.
- Applying the enablement model to maximise, and maintain, the patients' independence thus empowering the patients.
- Support patient flow from acute Secondary Care beds by facilitating a swift and timely discharge.
- Cost effective by reducing acute bed days within acute and community hospitals.
- Lessens institutionalisation, the risk of contracting Hospital Acquired Infection, delirium and confusion.

To date the hospital to home team have supported 50 people to no longer need a care package, increased an individual's independence and therefore reduced the amount of support 28 people required and have supported 7 palliative patients who were cared for and died at home. The service has scored 97% satisfaction rates by patients and their families, 429 patients over the last 2 years have received the services of the team (data from the past year).

Hospital at home

This service is led by a Lead clinician and seeks to support the twin goals of avoiding unnecessary Hospital admissions, and where an admission is necessary, to support the patient's prompt Discharge from hospital back to their own home in the community. The service brings together the multidisciplinary team (MDT) and integrates this around the needs of the patient, setting goals and implementing a care plan to reach these goals through continuous review and monitoring that takes place at the daily huddle where all members of the team meet to discuss progress.

The service provides an urgent assessment that is responsive and able to provide monitoring and intervention for patient with an acute episode of illness that would otherwise require to an acute hospital admission, working with all members of the multidisciplinary team to get the patient seen in the right place at the right time by the right person who reviews the patient on a regular basis. The service works with teams who already exist within the community, such as the district nurses and general practitioners to achieve the best outcome for the patient within their own home setting.

The team have a half time lead clinician , a GP who provides two sessions per week and a full time Staff Grade doctor, to support the service which has provided care for over 800 patients to date. Updated figure. The service have recently seen the addition of three band 3 care support workers who have been introduced to the team , the purpose of this additional resource is to support patients in the community with personnel care until the acute phase of their illness has subsided.

Care Home team

Provide support and guidance to the 17 care homes in East Lothian. They identify training needs and provide education, facilitate access to specialist services when required. They work closely with East Lothian Council when concerns are raised or investigated.

The aim of the service is to help maintain quality care, improve standards of care, aide staff to access the skills and knowledge needed to care for their residents, prevent unnecessary hospital admissions, facilitate hospital discharge for complex cases and to improve links and access to secondary care services.

They work in conjunction with other teams to ensure that residents within the care home setting are supported to remain within their home.

Care at Home

Care at Home services can help to provide support to allow people to continue to live independently in their own homes. This may need support on an ongoing basis, or for a short period of time, such as following a stay in hospital while individuals recover or adapt to new circumstances. Care at Home staff can help with personal care tasks, such as:

- washing and dressing
- taking and managing medication
- going to the toilet
- help with preparing and eating meals

Care at home services are offered seven days a week (including public holidays) and can be provided by in-house or by private providers. The Health and Social Care Partnership contract with around 20 care at home providers to provide high-quality care and support. Managing the different

geographies and rural/town landscape provides huge challenges for all the providers across the county

Daily Huddle review of East Lothian discharges
To ensure that effective and efficient use of all intermediate care resources and to get patients to the right place at the right time a daily huddle has been introduced, which is multi-professional and looks at getting patients who have been admitted to the right place, this may be discharged with a package of care with or without discharge to assess. Alternatively patients may be discharged home without any care or be supported to residential or care home setting.

A decision is made at that meeting is also made to pull patients to ELCH if admitted to RIE or the WGH so that they are closer to home so that local services can be involved in discharge planning but also improve and enhance communication with relatives and carers.

Integrated Care Assessment and Allocation Team ICAAT
The main function of the team is to review and process referrals for package of care requests enabling individuals who have been assessed as needing CAH support to receive the appropriate care they require in the right way at the right time. This is achieved through the multidisciplinary team meeting on a regular basis to agree priorities cases.

Nursing: The nursing staff within the team will screen the referrals that are received daily from the hospital, they will manage the most urgent referrals addressing each individual resident or patients' personnel needs at that time to support them to continue to live in the community.

Social Work: The social workers main role is work with their colleagues to escalate and address key issues that need progress to support individuals to be discharged from hospital, supported more effectively in the community, receive respite, or admitted into nursing/residential long term care.

Social Work staff also meet with the providers to work with them to help recruit staff to provide care in the community. The Social Work Staff also work with Community Care Brokers to ensure that all Providers are working as efficiently as possible, clustering providers into small areas to reduce travel time.

Occupational therapy: Occupational therapy team will screen the admissions received overnight highlighting those that could or should be supported back into the community back to their own home. They will assess a referral for care if there has been a change in an individual's condition or circumstances that needs a mobility or environmental assessment.

Emergency Care Service (ECS)
The ECS team delivers a 24-hour support service for all adults anywhere in East Lothian, responding to calls made through personal alarms pendants, wristbands and telecare systems, for example, door sensors, fall detectors as well as self-referrals from people who do not have an alarm system installed in their home.
The ECS service has two teams. ECS 1 who provides short-term support service to clients to prevent their admission to hospital. This includes early intervention to prevent escalation of situations as well as one off visits that only require a single carer.

The second team, ECS 2 works in pairs, answering emergency calls to people who have fallen. They also provide some short term support to clients to prevent hospital admissions.
The role of this team is increasingly supporting people who are at the end of their life and wish to die at home allowing the wishes of individuals to be carried out, keeping them as comfortable as possible and also supporting their families. ECS adopts a holistic and collaborative approach when supporting a client, working with several agencies to look for ways to increase the safety of a person in their home and checking on their wellbeing to prevent further falls and prevent admission to hospital.
Recently, ECS 1 provided over 2400 visits to 302 clients. ECS 2 responded to over 7600 calls of which over 1700 were from people who had fallen and could not get up themselves

Primary Care
General practitioners and their teams treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.

Care When it Counts (CWIC)
The Care When It Counts service is a nurse-led service, supported at times by GPs or Physician's Associates. It offers same-day appointments to patients at a number of GP Practices across East Lothian, who have new symptoms or flare-ups of existing conditions. Patients are referred to CWIC via calling their Practice.
If an individual calls about a new health concern (or a flare-up of an existing condition) which they think needs attention that day, the care may be provided by the CWIC service.

CWIC (Mental Health) is a primary care service for people in East Lothian aged over 17 years and 9 months. They work closely with GP practices, Adult Mental Health services and local third sector services to help access the right support for an individual's needs.

General practice has an important role in looking after patients in their homes and within the communities where they live. They are part of a much wider team whose role includes promoting, preventing and initiating treatment. They look after patients with chronic illness, with the aim to keep people in their own homes and ensuring they are as well as they possibly can be.
General Practice is often the first point of contact for anyone with a physical or mental health problem and patients can be at their most anxious. Looking after the whole person - the physical, emotional, social, spiritual, cultural and economic aspects through patient-centred approaches is a vital part of any GP's role. This is becoming more important with terminally ill patients often choosing to stay at home.

Additional support to Intermediate care

Additional support to Intermediate care

Additional support to intermediate care services (listed above) are highlighted below. They are an integral support and also play an important role in keeping someone at home for as long as possible as well as helping to keep individuals well and safe and hopefully prevent or reduce hospital admission.

East Lothian Community First (ELCF)

The aim of this service is to improve the health and wellbeing of local people through better connections to appropriate sources of support within their local communities, including the use of volunteers. The service was initially set up as a test of change in collaboration with ihub (the Improvement Hub of Healthcare Improvement Scotland) in 2017 to support hospital discharge of people who did not require ongoing care services. The service has since expanded in 2021 to provide support to people at home.

The support provided by ELCF will include an extended range of activities: meeting with the person in the hospital/home to talk about what they would like to achieve (talking through short and long term goals and gathering the information of the 'nominated contact' or community champion); practical support such as ensuring utilities are in place; support to engage with meaningful daily activities; assistance and support to go for prescriptions or shopping (either volunteer or nominated person); support to access and contribute to their local community and support to reduce social isolation. Support is tailored to each person and agreed personal outcomes are set; if further support is required then signposting to relevant agencies will be provided. Support is reviewed after 8 weeks.

Alzheimer Scotland PDS Link workers

Improved post-diagnostic information and support was recognised as an area in which immediate change was required in the National Dementia Strategy 2013 – 2016. It focused on providing good quality of life at home for longer, supporting the development of dementia-friendly local communities, timely, accurate diagnosis, and better post-diagnostic support

Alzheimer Scotland have been commissioned to provide Post Diagnostic Support Link Worker support in East Lothian since 2015. Funding now supports 2 x 35hr Post Diagnostic Support workers, initially funding had supported 1 support worker. Demand and subsequent increasing waiting lists supported additional investment.

The Post Diagnostic Support Link Workers are based within the Community Mental Health Team (CMHT). Supervision is provided through the CMHT once a month to support with team issues or any concerns with the people they are supporting. Each worker carries a maximum of 50 active cases. Each person supported receives a person-centred support plan based on their individual needs, desires and aspirations including the '5 Pillar of PDS' and the Link Workers are trained to the enhanced level of the national 'Promoting Excellence Framework'

A key aim is to deliver sustainable, continuous post diagnostic services across East Lothian. This can best be achieved by giving the current service provider flexibility in developing the service over three years, rather than being tied to a year on year funding system which has caused difficulties with regards to recruitment and retention over the last 3-4 years. There is an established evidence base for PDS provided by Alzheimer Scotland currently.

A recent successful funding proposal (following a 12 month extension as of April 2022) was to award funding to Alzheimer Scotland specifically for post diagnostic funding for a minimum 3 year contract.

Older People Day Centres

The existing funding for older peoples centres is continued until 31 March 2023. This will allow time to undertake further work, taking note of the issues outlined below and with the aim of developing a longer term integrated framework model for both centre and outreach from April 2023.
The IJB has agreed the underpinning principles for Day Centres:

- Commissioned to deliver local services that reflect the varying needs of the local communities
- Flexibility of provision allowing for both centre and community based services which address fluctuating COVID-19 restrictions ('blended model')
- Reduction in carer stress
- Preventative in nature reducing social isolation and loneliness
- Innovation in dementia care and support
- Effective governance arrangements based on genuine partnership and collaboration with providers and communities

Carers funding and support

Carers funding and support

As Carers are significant and integral part to supporting individuals to remain at home for as long as possible recent, short term funding extensions have been supported. These will require assessment and review of longer term funding options. A few of these are set out below for information.

It is worth highlighting that Carers are providing a huge contribution to Intermediate care services, not necessarily in relation to the more formal health and social care definitions but their essential role and future support must be recognised.

Extend Older People's Day Centres Outreach.

Building on the success of the day centre outreach it supports carers needs for additional respite through outreach support. This can involve centre staff visiting people at their homes or delivering meals, when someone is house bound. *Increase in Funding to Voluntary Centre East Lothian* ***VCEL*** to develop their Community Outreach service which will be integrated with Community Support Service(s) – Hospital Discharge and the Community Taskforce. Based within the local community setting, the service addresses concerns, difficulties and issues that an individual presents with to reduce isolation, carer stress and issues escalating.

Dementia Cafes

Alzheimer Scotland. Two dementia cafes in Musselburgh and Dunbar. Providing peer support and professional advice for people who are living with a diagnosis of dementia and their carers.

Meeting Centres

The development of the Meeting Centre in Musselburgh to support people living with dementia is now in place in Musselburgh with work being undertaken to look at a centre to the east of the county.

Summary

Summary

This paper describes what we mean by the broad term of intermediate care and show examples of those services provided in East Lothian. Also emphasising why they are an important focus of our services already established within the Health and Social Care Partnership. There are other models out-with East Lothian that we would like to learn from too and we are working with Health Improvement Scotland to look at these.

Importantly, we want to listen and hear from people across East Lothian as part of the Communications and Engagement work as to what services people liked, their own experiences using them and what other intermediate care provision they would like to see in their communities.

We would like to discuss their ideas and thoughts on these services in their local areas and what opportunities there are to bring together/co-locate services together e.g. health, social care, third sector, independent sector, Voluntary. We want this work to form part of the basis for ongoing co-production of how we can develop these services across East Lothian reflecting the differences across the county and the local communities to try and develop local services.

We know there are unrelenting pressures on beds and we have set out in other papers our thoughts on these. There needs to be further debate, focus and resources on developing more Intermediate care provision. There is so much more being done and much more we would like to do to keep people at home, for as long as possible enjoying a high quality, healthy life surrounded by their family and friends.