**The Intermediate Care Team (ICT) in Shetland**

ICT has been established for three years. It recently expanded with recruitment of a third Occupational Therapist, two rehabilitation support workers and an Advanced Nurse Practitioner. These joined the existing team of two Occupational Therapists and 5 rehabilitation support workers and the team manager.

The geography of the 15 inhabited islands makes it a challenge for the team to deliver an equitable service - the two most northerly isles, Unst and Fetlar, are 60 miles and two inter-island ferries away from central Shetland. Prior to the expansion, the service was limited to central mainland Shetland.

**Expanded Team Remit**

Despite the expansion, it was not possible to replicate the central team in the more remote locations. The team therefore developed a model of Intermediate Care supporting people from central care centres where intensive reablement can take place until they are able to return directly home, or home via their local care centre, with less intensive support, using:

- A strength-based, holistic, assessment of the person, their environment and existing support network.
- An approach that supports clients to transition from care centre/hospital to home and ensures that staying at home is sustainable
- Shetland’s strong community.

**The expansion of the Intermediate Care Team enabled:**

- Increased numbers of clients accessing the service.
- Supported clients to return home to some of Shetland’s most remote locations.
- Reduced admission to long-stay care home placements.
- Ultimately clients are not disadvantaged because of their home location.

**How was this achieved?**

- Completed ICT awareness raising sessions to external and internal agencies;
- Built stronger links with care centres and care providers in the northern isles;
- Identified clients whose home location is a barrier to returning home;
- Identified risks with the client, family members and local care staff;
- Devised reablement plans for clients while in care centres;
- Completed comprehensive plans for transition home and on-going support from ICT and the local care providers.

**Outcomes**

ICT is now inclusive for all clients and is no longer based on their home location.

Clients have successfully been supported home to the north isles utilising their communities, local resources and health and social care services.

Referring agencies are now aware that they can refer a client regardless of their home location in Shetland.

**Nancy’s Journey**

Nancy fell while visiting family in London and spent 8 weeks in hospital. She wanted to return HOME.

- **London Hospital**
  - Liaison with family
  - Liaison with London hospital staff including ward Occupational Therapist
  - Planning with interim care centre staff in Lerwick for transition back to Shetland.

- **Lerwick Interim Placement**
  - Initial Occupational Therapy assessment.
  - Goal Setting in collaboration with Nancy.
  - Joint working with physiotherapy and social work.
  - Reablement Plan completed and communicated to care staff to implement.
  - Input by Rehab Support Workers.
  - Progress reviewed regularly.
  - Planning for transition to care home on Unst.

- **Unst Interim Placement**
  - Reablement plan updated and new goals set with Nancy.
  - Continence assessment undertaken by community nurse.
  - Environmental assessment completed.
  - Nancy visited her home with family prior to returning.
  - Care package put in place to support with personal care.
  - Meals on Wheels put in place.

**Contact**: Shetland Intermediate Care Team 01595 745314  
Denise Neild  Occupational Therapist  
Denise.Neild@nhs.net

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**Number of clients accessing Intermediate Care across Shetland**

- **Morland**
- **Northern Isles**

**60° N**

**Shetland**

**Unst**

**Lerwick**

**Nancy is now successfully living at HOME with support**

- Tenacity and support from London hospital staff;
- Tenacity and communication from ICT and local care providers.
- Above all support from family.

**NHS Shetland**

**70 YEARS**

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