

VFM Audit Intermediate Care - Executive Summary

1.1 The recent DoH White Paper (January 2006) *Our health, our care, our say: a new direction for community services*, documented that in England investment in intermediate care and related community services since 2001 has resulted in a reduction in delayed discharge from acute hospitals of 64% by September 2005.

1.2 The White Paper also identifies that in the future, an increased amount of care will be provided in local and more convenient settings, as:

- People's expectations are demanding this;
- Changes in technology and clinical practice are making this safer and more feasible; and
- The implications of an ageing population means that the financial demands on the health and social care system necessitate alternatives to high cost acute hospital provision.

1.3 As a result, the White Paper identifies a response for future service delivery that has a focus on prevention and supporting individual well being in the community, as needing to be prioritised. Intermediate care provision is seen nationally as an aspect of such a response.

1.4 Within the National Services Framework for Older People, the aim of intermediate care was stated to be: "*to provide integrated services to promote faster recovery from illness, prevent unnecessary hospital admissions, support timely discharge and maximise independent living.*"

1.5 In Northern Ireland as well, the annual *Priorities for Action* document has provided additional resources for the development of intermediate care locally, designed to streamline the patient journey, facilitate earlier discharge and reduce unnecessary admissions to hospital. Whilst, *Investing for Health, A Healthier Future* (DHSSPS, 2005) set out a vision for the health of the Northern Ireland population over the next 20 years and with it a strong focus on promoting public health, engagement with local communities, the development of responsive integrated services aimed at treating people in communities rather than hospitals, new effective and efficient ways of working through multidisciplinary teams and improving the quality of services.

1.6 As a result both nationally and locally there has been considerable investment in intermediate care and expectations have been high that it will achieve desired changes and the outcomes for service users. Consequently it is also important that information is collated and analysed about these services and what they are achieving in order to understand the impact they are having and assist their further expansion as well as promoting the support of professionals from the primary and secondary care settings in the provision and referral to such services.

1.7 It is within this context, that the DHSSPS within Northern Ireland commissioned PricewaterhouseCoopers LLP (PwC) to examine the economy, efficiency and with which intermediate care services are provided at Trust level, with Board and Departmental input also being ascertained. Amongst the key findings from the audit were the following:

- **At a national level there is evidence from the literature about the benefits of intermediate care to both the individual and the system as a whole.** These have included increased throughput and capacity in the acute hospital sector, effective care close to home, increasing the use of technology, and integrating systems to ensure that people are placed in appropriate locations in a timely manner. The most recent evaluation (*National Study of Intermediate Care, Universities of Birmingham/Leicester, December 2005*) found that:
 - Locally, intermediate care has been driven by the need to address pressures on acute beds;
 - For users, intermediate care was thought to represent patient-centeredness, flexibility and opportunities for independence;
 - The main concerns surrounding the implementation of intermediate care centred upon capacity issues and whole systems working;
 - The suggestion that intermediate care is providing an additional as well as substitute service was supported by the findings of a staff survey;
 - There is no defined national standard for data collection with the result that outcome measures vary widely between schemes; and
 - Residential intermediate care services were found to have a higher cost per user than non-residential services.

- **In Northern Ireland, there is evidence of a wide ranging approach to the development of intermediate care.** Across Trusts there are now a number of individual intermediate care projects in place (53 schemes in 2005/06) that offer an alternative to hospital provision and/or assist in the earlier discharge of individuals from the acute setting. In 2004/05 there were 14,294 users on intermediate care schemes and in 2005/06 this had risen to 17,662.

- **In 2005/06 there was a total budget of £12.9m allocated to intermediate care on the basis of Trust's classification of schemes as intermediate care.** At a whole population level in Northern Ireland in 2004/05 an estimated £6,605 per 1,000 head of population was being spent on intermediate care schemes. In 2005/06 this was predicted to rise to £7,545. On the basis of research carried out by Leeds University the spend per head of population in 2003/04 (the latest years for which information was available) nationally was estimated at £10,499 per 1,000 head of population.

- **Overall by 2005/06, the majority of current intermediate care schemes were in place (91%).** However, across Board areas there has been varying degrees of consistency in the focus of such schemes (e.g. a spread of scheme types in the EHSSB, a focus on rehabilitation in the NHSSB, step up/down in the SHSSB, and rehabilitation and rapid response in the WHSSB).
- **A variety of schemes and variations of them has evolved across Trust areas but not all of these have the potential to maximise benefits due to a variety of factors.** For example, differences in capacity levels, geographic coverage, hours of operation (57% of schemes were provided across all Trust localities. The majority of schemes were provided during 'normal' working hours, out-of-hours and weekend arrangements were less well defined. Schemes were open to users above 18 years of age, but in practice users were primarily aged over 65 years), scope and nature of schemes, for example are they really intermediate care provision or traditional services re-badged as intermediate care?
- **There is evidence of good practice occurring within the HPSS sector with respect to a number of aspects of intermediate care provision (e.g. user involvement in SHSSB and associated Trusts, evaluation of outcomes and impact in the EHSSB).** It would appear that, generally speaking, these can be attributed to initiatives at local Trust and/or Board level and the determination, drive and commitment of groups of staff who have reacted to identified need and/or recognition of the need to seek to produce robust data in relation to such care.
- **Increasingly the DHSSPS and Boards have now become proactive in relation to providing policy direction, guidance and future planning with regard to intermediate care provision.** However, a previous lack of wider service planning has also meant that it could be argued intermediate care has not yet reached its full potential in Northern Ireland such as in including housing in the development of extra care schemes to develop community based services and the contribution of the voluntary sector to intermediate care achieving more. Although a number of schemes have involved partnership working with other Trusts or GPs, overall the role of the voluntary sector in the joint provision of intermediate care schemes has been limited in Northern Ireland.
- **Trusts are demonstrating ways in which intermediate care provision is positively contributing especially with respect to individual independence and well being.** However the availability of information on bed days saved, A&E attendances or delay discharges avoided has been less well recorded and developed. Although increasingly professional staff and managers are aware of the need for such mechanisms to ensure service users gain from the best approach and that the health and social service economy maximises the benefits that could accrue to it. There appears to be a willingness and desire to review the approaches applied to intermediate care with a view to directing potential future investment in

light of evidence gained, especially from the acute sector.

- **Nationally research carried out by the Universities of Leicester/Birmingham found that inpatient care was generally more expensive than care delivered at home.** Using a case study approach the study found that admission avoidance (non-residential) cost £800 per episode and supported discharge (non-residential) £1,133 per episode.
- **On the basis of the audit exercises findings, across Northern Ireland there were notable variations in terms of the budgets for intermediate care schemes, average number of users and hence the average cost per user.** It is therefore difficult to quantify whether one scheme has any particular value over another, however what does emerge is that schemes designed to keep people out of hospital were, in general, less expensive than those caring for someone after an acute episode. This was also the result of the national evaluation study of intermediate care as found by the Universities of Leicester/Birmingham.

Table 1.1: Summary of Northern Ireland Schemes

Scheme Type	Budget Range 05/06	Average No. of Users	Delivery Team Size	Average Caseload per Team Member	Average Cost per User	Average LOS on Scheme (Days)
Home from Hospital	£39k-£299k	294	NA	NA	£483	24
Rapid Response	£18k-£578k	541	1.25-6.97	37	£417	15
Rehabilitation	£31k-902k	189	1 – 9.6	29	£1,288	50
Step up/down	£67k-£546k	161	2.25-8.7	48	£1,196	17
Stroke	£164k-254k	112	3.6-7.6	23	£2,001	78
Community Hospital	£1.5m	1,073	NA	NA	£1,431	19
Miscellaneous	£37k-£145k	212	NA	NA	£479	8

Source: Compilation of analysis from PwC Intermediate Care Data Return 2005

- **Applying cost information from the national evaluation and comparing the cost of a hospital stay versus the cost of intermediate care schemes provided by NI Trusts identified that overall there were savings gained by intermediate care provision.** In particular on the basis of the cost of a weekly inpatient hospital stay as applied in the national evaluation study and if various scenarios were considered, whereby rather than avail of an intermediate care scheme, a service user stayed in hospital for either 14 or 7 days and upon discharge received support at home for a period of 4 or 2 months, then savings (through the user of intermediate care in substitution for a hospital stay) were

identified as detailed in Table 1.2.

Table 1.2: Scenario Modelling - Intermediate Care Scheme Cost Saving

	14 Day Hosp 4 Month Supported Discharge		14 Day Hosp 2 Month Supported Discharge		7 Day Hosp 2 Month Supported Discharge	
	Max Saving provided by IC	Min Saving provided by IC	Max Saving provided by IC	Min Saving provided by IC	Max Saving provided by IC	Min Saving provided by IC
Average cost per user	£4,243	£2,659	£3,075	£1,491	£1,913	£329
Maximum cost per user	£4,923	-£1,458	£3,755	-£2,626	£2,222	-£4,159

Source: Compilation of analysis from PwC Intermediate Care Data Return 2005 NB: Negative values indicate that hospital stay would be potentially cheaper than an intermediate care scheme Section 11 provides further detail on these savings by intermediate care scheme type, eg. Rapid response, rehabilitation etc.

- **The indications from the audit were of increasing confidence from primary and secondary care in making good use of intermediate care and of understanding its impact on individuals.** Both staff and users were positive on the role of intermediate care and the impact that it can and does have on the individual as well as the healthcare system as a whole.
- **However, there was the view from acute sector staff that further work was required to demonstrate the effectiveness of intermediate care.** In addition, the extension of such care to more complex patients was an area where they envisaged more tangible and transparent benefits.

Table 1.3: Desired Developments in Intermediate Care

Community & Combined Trusts	Acute Trusts
<ul style="list-style-type: none"> • A clear definition of intermediate care and which elements are most important to the DHSSPS; • Teams based in one location to facilitate multidisciplinary working and access to a single patient record; • Co-ordinated system wide planning for intermediate care schemes • Increased medical involvement and the ability to call on medical staff when required; • Improved integration with care services including domiciliary care; • Improved use of IT and communications for referrals and measurement of outcomes; and • Formalised user involvement 	<ul style="list-style-type: none"> • A single point of referrals for all schemes in any Trust area; • A possible rationalisation of schemes across Northern Ireland to ensue common schemes are in place in all board areas with like entry criteria; • Co-ordinated and system wide planning for all schemes involving stakeholders; • Increased ability of Intermediate care schemes to take on more dependent patients; and • Availability of Intermediate Care 24/7.

Source: PwC interviews with Trust staff

- **Users reported high levels of satisfaction with the: Management of the start of their care; treatment they received; and level of recovery they made whilst on the scheme.** However, they indicated some scope for improved management of the transition between intermediate care provision and mainstream service provision.
- **Awareness of intermediate care amongst HPSS professionals has largely evolved on an informal basis.** The findings of the staff survey tend to suggest that a more formalized awareness of intermediate care, inclusion criteria and the role of schemes could provide a greater support, and hence impact upon whole

systems working.

- **The results of the case study exercise for the 3 classifications of schemes reviewed** (rapid response, step up/down and rehabilitation) suggested that in the absence of these schemes **the impact would have been:**
 - GPs, acute medical wards and orthopaedic and trauma wards having to **identify alternative referral routes;**
 - **More users being in an acute hospital setting** and residential and nursing homes, with less staying in their own homes; and
 - **More medical staff input required** as well as physiotherapy, social work as well as acute nursing and occupational therapy.

- **With respect to the location of location of care delivery and the case study exercise, fewer people had an overnight stay in an acute hospital after being discharged from the case study intermediate care schemes** than would have been anticipated by the professional staff involved if the intermediate care scheme had not been in place. Furthermore a large proportion of users were cared for in their own home and based on professionals' opinions a large proportion of these users would have been cared for in an acute hospital in the absence of the intermediate care scheme.

- **Table 1.4: Overview of Case Study Results**

n = number of users	Rapid Response Schemes (n=161)	Step up/down Schemes (n=85)	Rehabilitation Schemes (n=134)
On basis of data return results:			
Average cost per user	£417	£1,196	£1,288
Average Length of Stay (ALOS)	15 days	17 days	50 days
On basis of case study results:			
User Goals Achieved	78%	71%	78%
Proportion of Users Cared for in Own Home whilst on Scheme	76%	78%	69%
Proportion Expected to be Cared for In Acute Hospital in Absence of Scheme (Staff's Professional View)	75%	53%	46%

Source: Compilation of analysis from PwC Intermediate Care Data Return & case study exercises, 2005

- **Introduction of intermediate care across the HPSS is still a work-in-progress in the sense of streamlining and refining the exact model(s) to be applied.** Due

to the complex nature of the organisations and services involved, there are no 'quick fixes' but there is clearly a vision and commitment to such provision. There also needs to be associated recurrent funding and support at operational and strategic level across primary and secondary care levels, along with realistic expectations of the pace of change.

- **In essence intermediate care has developed on the basis of a variety of individual projects at Trust level as opposed to a widespread integrated service development in Northern Ireland.** The challenge therefore in taking intermediate care forward is to ensure that an appropriate number of the 'right' schemes are in place across geographic localities and that they are integrated into the patient pathway along with the essential integration of the key professional skills whether they be AHP, nursing or medically based.
- **As the population ages over the coming decades** (in 2002 there were some 395,362 persons aged 55 or over (23% of the population) in Northern Ireland and by 2015 this is expected to rise to 492,932 persons (28% of the population)), **along with people's changing expectations of where they want their care delivered, there will be even greater demands on the health and social care system.** A key focus must therefore be prevention and support of individuals in as far as is feasible in the community, i.e. fundamental objectives of any form of intermediate care provision.

1.8 On the basis of the work undertaken a number of recommendations have been determined for collective action by health and social services Boards and Trusts and the DHSSPS as appropriate. These should be considered in the context of:

- The implementation of RPA and the associated reconfiguration of a number of health and social services bodies, should provide an ideal opportunity to streamline models of intermediate care provision and co-ordinate policy in respect of this area across Northern Ireland; and
- The future commissioning of targeted research in respect of intermediate care would help further inform and contribute towards the delivery of more effective and efficient services. More specifically, the implementation of a single assessment tool should also be an interesting development and its impact on the delivery of intermediate care provision should be an area for future monitoring and review.

1.9 The recommendations are as follows:

- (i) Review the key elements of the DHSSPS definition for intermediate care and consider the need to be more prescriptive – to avoid the reclassification of mainstream services as intermediate care;
- (ii) Review and agree on the most appropriate outcome measures for intermediate care schemes, as well as the methods for capturing such information and the

definitions underlying the collection and interpretation to promote robust collation of such information;

- (iii) Further develop and fund intermediate care schemes within a framework which promotes consistency of provision across geographic areas, and the implementation of schemes which can demonstrate real effectiveness in terms of outcomes and whole systems working;
- (iv) As a result of (iii), review the scope for increased capacity in the delivery of identified schemes, as well as appropriate geographic coverage across entire Trust catchment populations. This should also consider the weekly hours of operation of such schemes and out-of-hours arrangements to promote equity of access;
- (v) Consider the potential increased involvement of the voluntary and private sector to play a more prominent role in assisting in the delivery of intermediate care schemes, and to promote further integration with care management;
- (vi) Consider the feasibility of extending intermediate care provision to incorporate those users with more complex needs and including those with mental health needs;
- (vii) Ensure that Trusts have appropriate processes and mechanisms in place to enable the routine monitoring of actual expenditure on intermediate care against budgeted spend;
- (viii) Liaise with NIAS on the development and operation of intermediate care schemes and associated transport requirements especially out-of-hours arrangements;
- (ix) Promote further awareness and highlight the scope of intermediate care to health and social services staff and GPs to encourage appropriate levels and types of referrals to intermediate care schemes. This may include the identification of local 'champions' to highlight the benefits of intermediate care through formalised mechanisms;
- (x) Support the increased development of generic assistant roles with consideration given to the feasibility of standard training requirements for such staff;
- (xi) Ensure user evaluation of schemes are a routine feature of provision as well as overall scheme evaluation;
- (xii) Review the mechanisms supporting the balance of continuing professional development with effective multidisciplinary working, in particular ensuring

the efficient and effective management of individual intermediate care schemes, whilst ensuring the appropriate clinical supervision and development of professional staff members. The feasibility of a single base location for intermediate care staff should also be a consideration;

- (xiii) Determine the potential for expanded medical input to certain types of schemes, that is medical input which occurs outside of the secondary care setting;
- (xiv) Consider the findings of the user survey in respect of the arrangements in place to prepare users for the time when the provision of intermediate care services ceases and determine if the quality of this transition can be enhanced;
- (xv) Ensure that schemes have referral processes and criteria in place and that staff and referrers are aware of these. This should include exploring if the appointment of discharge co-ordinators and/or 'casefinders' promote the consistent application of such criteria and effectively support schemes routinely delivering to their capacity; and
- (xvi) Consider the establishment of a formal intermediate care learning network as a support and educational mechanism for intermediate care co-ordinators, as well as a means to promote communication with the acute sector over such provision and its future joint development.