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Department of  
**Health, Social Services  
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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Your Ref:  
Our Ref: **Circular HSS (EPCC) 2/2007**

Date: 13 March 2007

To: Chief Executives of HSS Boards and Trusts

Dear Colleague

## **INTERMEDIATE CARE**

1. Circular HSS (ECCU) 2/2005 entitled "Intermediate Care" was issued to Boards and Trusts on 26 April 2005. The circular stated that the Department intended to do further work on developing its understanding of intermediate care and its impact in terms of improved efficiency and outcomes. It also stated that it expected the outcomes of a major VFM study, looking at intermediate care, to make an important contribution to the development of strategic thinking in this area.
2. The purpose of this circular is to build upon HSS (ECCU) 2/2005 by drawing on the findings and recommendations of the PricewaterhouseCoopers Report on Intermediate Care, which have been endorsed by the Department and may now be found on <http://www.dhsspsni.gov.uk/audit-intermediate-care.pdf>. As well as reporting on the PwC findings and taking initial steps to secure a regional approach to the expansion of intermediate care, the Department is also signalling its intention to work with colleagues in the HPSS to further refine overall and individual scheme definitions.

## **INTRODUCTION**

3. In recent years increasing demands on the acute sector, particularly in A&E Departments, have been evidenced in some of the difficulties we have seen around inappropriate admissions to hospital, waiting lists and delayed discharges. A key element of HPSS reform and modernisation plans is the need to develop fully integrated primary and community care services that focus on people at greatest risk by supporting them to live independent lives and reducing unnecessary and inappropriate reliance on hospital services.
4. The development of intermediate care is absolutely crucial to the achievement of that objective. We are already seeing how robust alternatives to hospital provision can make a real and positive difference to people lives by providing care in more appropriate settings and ensuring that resources are committed in more effective ways. Intermediate care can, at the same time be a bridge to effective acute intervention and a

barrier to inappropriate admissions. Another by-product of intermediate care is improved quality of decision making about long –term health and social care needs.

5. In his keynote speech in June 2006, the Minister called for Commissioners and Trusts to work together to develop a range of fully integrated primary and community care services for their area, focussing on people at greatest risk and supporting them to live independent lives for as long as reasonably possible. He stated that he expected this to take the form of a comprehensive reform and service improvement programme including the development of a range of intermediate care services, specifically designed to bridge the gap between hospital care and continuing health and social care in the community. He pointed out that he wanted decisions about longer-term care needs to be taken in the most appropriate setting – calmly in the community after a period of support, and not in hospital when people are at their most vulnerable.
6. There is a growing weight of evidence that intermediate care has the potential to provide the right environment for multi-disciplinary working, delivering flexible and responsive services to meet person centred care plans. This can support our overall objectives in a number of important ways:
  - Freeing up hospital beds for more appropriate use by reducing inappropriate admissions and facilitating timely discharge from hospital;
  - Helping to support targets on waiting times enabling the HPSS to respond more effectively to emergency pressures;
  - Reducing reliance on institutional care and intensive domiciliary care by offering opportunities for rehabilitation; and
  - Building user and professional confidence in services designed to support independent living and enhance general quality of life.

## **KEY RECOMMENDATIONS FLOWING FROM THE PwC STUDY**

7. As a result of their study PwC has made a number of recommendations for collective action by Commissioners, Providers and the Department. These recommendations are wide ranging and whilst some can be achieved in the short term others are of a more long-term nature. The Department will be consulting with HPSS colleagues about the need for further guidance beyond this circular. In the meantime, however, commissioners and providers are expected to take the PwC recommendations fully into account for existing and planned intermediate care provision. A full list of the recommendations can be found in **Appendix 1**.
8. Central to the PwC recommendations is the need for intermediate care to be expanded within a regional strategic framework that will promote equity of access to a full range of schemes, which are efficient in terms of throughput and effective in terms of outcomes and whole systems working. PwC has also identified the need for further refinement and extension to individual scheme level of the Department's current definition of intermediate care. This will help ensure that schemes all have fundamental components such as proper referral mechanisms, access criteria, measurable outcomes and user evaluation.

## **RESPONSE TO PWC RECOMMENDATIONS**

9. The Department, in conjunction with colleagues in the HPSS, plans to review the key elements of the Department's definition for intermediate care as outlined in Circular

HSS (ECCU) 2/2005 and issue further guidance. (**Reference** - recommendations (i) in **Appendix 1**).

10. The study carried out by PwC has made it clear that the Department needs to provide a clearer strategic lead for the development of intermediate care services across Northern Ireland. This is to ensure that there is consistency in provision and that only those schemes that are effective in terms of outcomes and whole systems working are implemented. Whilst there is evidence of good practice occurring across the HPSS with respect to a number of aspects of intermediate care provision it has tended to be on the basis of a variety of individual schemes, with each Board area having a different focus, as opposed to widespread integrated service development of a range of schemes. Schemes have evolved across Trust areas and this may have led to equity of access issues as some schemes are confined to specific geographic localities. Additionally, for a variety of reasons, not all the schemes which have evolved have the potential to deliver on the maximum benefits of intermediate care. (**Reference** – recommendations (iii), (iv), (v), (vi), (vii), (xi) & (xv) in **Appendix 1**)
11. The Department accepts the PwC findings in this regard and recognises that the benefits set out in paragraph 5 above can only be realised if each local health and social care economy develops the full range of intermediate care services, as described in **Appendix 2**. This will ensure not only an integrated and systematic approach to the development of intermediate care services but will also underpin equity of access for service users. However, these general definitions are not intended to be prescriptive and, as already stated in paragraph 2, the Department will work with colleagues in the HPSS to further refine overall and individual scheme definitions and issue further guidance.

## **PLANNING AND PERFORMANCE MONITORING**

12. Under the terms of Circular HSS (ECCU) 2/2005, issued by the Department on 26 April 2005, Boards were required to review their intermediate care plans and report on general progress and the effectiveness of individual schemes. This information was required to give assurance about the continuing development of intermediate care and to allow the Department to take a view about its impact on a regional basis. Responses indicated that Boards had, to varying degrees, taken steps to develop intermediate care services in their areas but some Boards clearly had inadequate systems to allow for the effective monitoring and evaluation of such schemes. Christine Jendoubi, Director of Primary and Community Care, wrote to each HSS Board Chief Executive in July 2006 regarding the adequacy of the information they had provided.
13. On the basis of the plans received from Boards and the findings of the PwC study the “Planning and Reporting Framework” contained in Appendix 2 of Circular HSS (ECCU) 2/2005 has now been refined and the updated framework is contained in **Appendix 3** of this circular. The Department expects commissioners and providers, if they have not already done so, to put systems in place before 31<sup>st</sup> March 2007 to capture the information contained in this framework so that the HPSS is in a position to offer assurance to Ministers about the roll out of intermediate care and its impact, as and when required.

## **SOCIAL CARE COMPONENT**


14. Intermediate care is time-bound and designed to promote independent living by providing effective interventions to avoid inappropriate reliance on hospital or other

institutional care. Under these circumstances, the Department accepts that the current practice of not subjecting these services to a means test should continue, even where the scheme involves a short-term placement in residential accommodation. In the event that such a placement becomes long-term in the context of continuing care, the normal Charging for Residential Accommodation Guidelines should apply.

## **SUMMARY**

15. Good progress has been made, with around 50 intermediate care schemes in place across Northern Ireland. More needs to be done, however, in terms of improving access and evaluating impact. The Minister has already signalled the role he expects intermediate care to play in delivering on the overall reform and modernisation agenda. Access to intermediate care services will be an important component in providing quality and safe alternatives to inappropriate hospital or institutional care.
16. This circular constitutes a preliminary response to the findings of the PwC Report. The Department will work with colleagues in the HPSS on all of the findings and plans to issue further guidance.
17. In the meantime, if you have any queries about the content of this circular please contact Mandy Jones; tel 02890 522930.

Yours sincerely



**ANDREW HAMILTON**

cc General Practitioners  
David Sissling  
Chief Executives of new HSS Trusts

### FULL LIST OF RECOMMENDATIONS FLOWING FROM PWC STUDY

- 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 that promotes consistency of provision across geographic areas, and the implementation of schemes that 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 cover 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 is a routine feature of provision 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 coordinators and /or “case finders” promote the consistent application of such criteria and effectively support schemes routinely delivering to their capacity.
- xvi)** Consider the establishment of a formal intermediate care learning network as a support and educational mechanism for intermediate care coordinators, as well as a means to promote communication with the acute sector over such provision and its future joint development.

### **STRATEGIC FRAMEWORK FOR THE DEVELOPMENT OF INTERMEDIATE CARE SERVICES**

The overall objectives for intermediate care must include:

- reduction of inappropriate admissions to hospital;
- reduction of delayed discharges;
- reduction in overall length of stay;
- improved assessment of long-term care needs;
- reduction of inappropriate reliance on residential or other intensive care packages; and
- improved opportunities for independent living.

The PricewaterhouseCoopers Report identified three broad headings, under which the intermediate care schemes necessary to address these objectives can be categorised. Commissioners and providers should work together to ensure that local health and social care economies develop a range of solutions under these three headings to address locally identified needs. The aim must be equity of access to ensure that reform and modernisation objectives are met consistently across the region.

#### **RAPID RESPONSE**

Rapid Response schemes aim to provide crisis intervention to users in their own home, or other locations, as a means of preventing unnecessary admission to hospital or as a means of facilitating timely discharge from hospital.

#### **STEP UP/STEP DOWN**

Step Up/Step Down Schemes aim to prevent unnecessary admissions to hospital or to facilitate timely discharge from hospital. Users normally require more intensive time-bound support or monitoring than could be provided through rapid response. The service may be provided in a person's own home, other normal place of residence or in dedicated beds within community facilities or care homes.

#### **COMMUNITY REHABILITATION**

Community Rehabilitation schemes provide time-bound support to help users regain maximum independence following an illness or an injury. These schemes may be longer-term in nature than Rapid Response and Step Up/Step Down schemes but should be delivered in response to a defined care plan and timescale.

#### **GENERAL**

In reviewing and developing all intermediate care services, commissioners and providers must also take the following into account:

- all intermediate care schemes must have referral processes and criteria in place and that all staff and “referrers”, including GPs, are aware of these;
- access criteria should be based on need, rather than specific client groups;
- consider the weekly hours of operation of intermediate care schemes including out-of-hours arrangements;
- liaise with the NI Ambulance Service on the development and operation of intermediate care schemes and the associated transport requirements, especially out-of-hours arrangements;
- consider the feasibility of extending intermediate care provision to incorporate those service users with more complex needs, including those with mental health needs;
- consider the potential for the increased involvement of the voluntary and private sector in the delivery of intermediate care services;
- ensure user/carer evaluation of schemes is a routine feature of provision as well as overall scheme evaluation; and
- ensure that they have appropriate processes and mechanisms in place to enable the routine monitoring of actual expenditure on intermediate care against budgeted spend.

**INTERMEDIATE CARE  
PLANNING AND REPORTING FRAMEWORK**

- Scheme name
- Scheme type
- Service location
- Target Group
- Service Provider Type (statutory/private/voluntary/other)
- Existing/new scheme
- Start Date of Scheme
- Core Activity Units – number of service users
- Supplementary Activity Units (may vary according to the nature of the scheme e.g. contacts, care hours delivered, bed days)
- Indicative volume (of activity units) per annum
- Indicative cost per annum
- Target number of users
- User days on scheme (total, average, maximum, and minimum)
- A&E attendances avoided
- Hospital bed days saved as a result of avoided admissions
- Hospital bed days saved as a result of reduced length of stay
- Hospital bed days saved as a result of reduced delayed discharge
- Intensive community packages reduced as a result of rehabilitation (number of packages reduced and total value of resources released for re-investment)
- Validate measurement of increased levels of independence (e.g. Barthel scores, elderly mobility scores, FIM/FAM)
- User experience