rehabilitation services
for older people

a bulletin for trusts and social care organisations

This bulletin highlights the main issues identified during our reviews of rehabilitation services across England and Wales. It is primarily aimed at chief executives and directors of service of NHS hospital trusts, primary care and social care organisations.
CONTENTS

Introduction 1
Exhibit 1: A vicious circle 1

Joining Up Rehabilitation Services 2
Box 1: Good practice – continuity of care 2
Exhibit 2: Services providing rehabilitation 3
Box 2: Good practice – joined-up services 3
Box 3: Good practice – a strategic approach 3

Engaging with Individuals 4
Box 4: Patient-focused services 4
Box 5: Good practice – involving patients directly in multi-professional goal planning 4
Box 6: Good practice – leisure co-ordinator 4
Exhibit 3: The shortfall in therapy 5

Access to Services 6
Box 7: A fragmented service 6
Box 8: Typical comments from GPs 7
Box 9: Good practice – preventative services 7
Box 10: Good practice – hospital assessment 8
Exhibit 4: Example rehabilitation ward census 8

Helping Agencies Move Forward 9
Box 11: Multi-agency workshops – a typical format 10

How Effective are Your Rehabilitation Services? 10
Who is District Audit? 11
INTRODUCTION

Rehabilitation and preventive services have an essential part to play in helping older people maintain their independence and a good quality of life. Effective rehabilitation services can prevent the need for older people to be admitted to hospital, facilitate their discharge from hospital and reduce their reliance on institutional care or community services.

The NHS Plans for England and for Wales, the National Service Framework for Older People in England*, the Intermediate Care Circular (HSC 2001/01), and the Audit Commission’s report on rehabilitation services *The Way to Go Home* all emphasised the importance of developing effective rehabilitation in hospitals and in the community. In a similar vein, the Personal Social Services Performance Fund for 2002/3 is to be used to develop and implement local schemes to improve intermediate care arrangements.

Yet our reviews show that very often, rehabilitation services are failing to make the necessary impact: services are unco-ordinated, they do not engage with older people as individuals and so cannot respond to their needs. Consequently, there is a risk of continuing the ‘vicious circle’ identified in the Audit Commission’s 1997 report *The Coming of Age* – as hospital admissions rise and lengths of stay shorten, there is less scope for recovery and rehabilitation. In turn, this places increasing (and unsustainable) demands on social services, leading to fewer preventative services helping older people at home, and once again to increased hospital admissions (see Exhibit 1).

Our multi-agency reviews focused on the rehabilitation of frail older people. Uniquely, we included a survey of the views of 4,000 older people undergoing rehabilitation and/or their carers and family members.

Exhibit 1: A vicious circle

Health and social services are locked into a vicious circle

- Admissions to hospital are increasing
- There is less money available for preventative services
- There are insufficient rehabilitation services
- People are being discharged sooner
- There is increasing use of expensive residential and nursing home care
- Pressures on hospital beds are increasing


An in-depth assessment of rehabilitation services is beyond the scope of this bulletin. Instead, we have focused on three areas identified as critical issues during our reviews:

- Joining up rehabilitation services
- Engaging with individuals
- Improving access to services.

* The Welsh Assembly Government is currently consulting on an Older People’s Strategy which will lead to the development of an NSF implementation plan in 2003.
JOINING UP REHABILITATION SERVICES

From an older person’s point of view, rehabilitation should be a joined-up service, helping them get back, as far as possible, to a normal life.

From the provider’s point of view, rehabilitation can be viewed as a succession of services, planned and provided by different agencies. Our audits show that problems arise when these agencies do not work effectively together to provide a seamless service to the individual.

For an older person, gaps in care can mean the difference between regaining an independent life in their own home, or not.

For the agencies involved, the lack of joined-up services can create expensive duplication of effort and further cost implications, if the person’s condition deteriorates to the extent that they need to go back into hospital. Moreover, it can also damage the reputation of the agency and possibly expose it to the risk of litigation.

Rehabilitation for older people might not seem to be a priority for trusts focused on waiting list targets. But the service has an important role to play in easing the pressure on beds, both by preventing admissions and facilitating timely discharge. It should also be a key priority in the development of intermediate care services, with continuity of care being promoted by intermediate care co-ordinators.

CONTINUITY OF CARE

There are many reasons why older people do not experience the seamless service they need. For example:

- Community therapy services are generally not geared up to deal with people discharged from hospital. Few have the capacity for work with frail older people.
- Social services often have long waiting lists to fit aids and adaptations in the home. In our survey of stroke patients, 47% said the equipment or adaptations they needed were not in place when they got home.
- Information about a patient may not be passed on from the acute hospital to rehabilitation teams working in the community or in day hospitals. Older people can find themselves subject to serial assessments, with assessments in the community duplicating those carried out in hospital.

The National Service Framework for Older People in England requires agencies to adopt a Single Assessment Process (SAP) by April 2004. This should help by ensuring that all those involved in providing care, at whatever location, have access to the patient’s single assessment.

But we found many sites were a long way from achieving this, and will need to make this task a higher priority if they are to meet their April 2004 target. Realistic action plans need to be produced to overcome the IT and operational barriers to sharing information between organisations.

Box 1: Good practice – continuity of care

United Lincolnshire Hospitals NHS Trust

Rehabilitation services in Lincolnshire recognised that continuity of care for older people depends on the availability of day and community-based services to complete the rehabilitation process, and to monitor and review progress. The Trust believed a way forward was to have more links between acute and community services. This led to the development of a community occupational therapy service based at Pilgrim Hospital, Boston, delivering a follow-up service for older patients in the community and so maintaining continuity of care.
Co-ordination across health and social care agencies is therefore essential to the development of rehabilitation services. Agencies need to work together in local strategic partnerships to plan to meet the rehabilitation needs of the older population. Yet the findings of our reviews suggest that many agencies are still a long way from establishing a joint strategic approach to rehabilitation. There is a lack of clarity about the issues that need to be addressed in developing a ‘whole system’ approach, and organisational change across healthcare, particularly at a strategic level, has also slowed progress on joint working.

Hospital trusts, primary care organisations, social services and voluntary agencies need to draw up a strategy for the development of rehabilitation services for older people using a whole systems approach. An improvement plan, to be phased in over three to five years, should deal with:

- How to bridge any gaps in the service
- Improving the management of care pathways
- Any therapy workforce implications.

**Box 2: Good practice – joined-up services**

**West Cumbria PCT and Cumbria Social Services intermediate care**

All intermediate care services have been brought together in a whole system approach. The range of multi-professional and multi-agency services are designed to maximise independence for older people, reduce avoidable admissions, facilitate timely discharge, promote rehabilitation and avoid dependence on institutional care. The team has produced an A5 laminated card to fit in the diaries of staff, containing referral criteria and guidance on the information needed to make a referral.

**Box 3: Good practice – a strategic approach**

**Neath Port Talbot rehabilitation strategy**

Bro Morgannwg NHS Trust, together with the Local Health Group and Social Services Department in Neath Port Talbot, identified the need to develop a shared approach to the provision of rehabilitation services. A multi-agency, multi-professional group worked over 18 months to define and understand local patient care processes. The group also had to decide what would be necessary for effective strategic planning. The work led to the first joint strategy for rehabilitation in Wales. The agencies are currently implementing an action plan with an initial focus on consolidating the relationship between hospital and community services. A particular objective is to ensure multi-professional assessment and management planning in the patient/client care pathway.
ENGAGING WITH INDIVIDUALS

One of the keys to effective rehabilitation is to engage with the patient – involving them in decisions about the goals they want to achieve and the care they will need to get there.

PATIENT-FOCUSED SERVICES

The evidence from our surveys of patients and their carers is that there needs to be a shift in approach, from fitting the patient into existing services, to starting from the individual’s needs and wishes and planning a multi-professional, multi-agency, joined-up response.

This patient-centred approach has been recognised by the Department of Health in the National Service Framework. But in our surveys of older stroke patients, about a quarter said therapists hardly ever or never asked them on what they wanted to work hardest.

For health and social services agencies, a change in culture is needed. Rehabilitation services need to move from regarding their remit as one of supporting older people, to one of helping people to help themselves, so they can become less dependent on support.

Box 5: Good practice – involving patients directly in multi-professional goal planning

Southam Stroke Rehabilitation Unit, Delancey Hospital, Cheltenham (now part of Gloucestershire Hospitals Trust)

Goal planning meetings are an integral part of routine care on Southam Stroke Rehabilitation Ward. At these meetings the patient and carers meet up with nursing and therapy staff. Progress and expectations are discussed and realistic goals set for the patient. These goals are reviewed at subsequent meetings and further goals set as progress is made. This approach has greatly enhanced the involvement of patients and carers in the treatment provided, and has improved the standard of care offered.

Box 4: Patient-focused services

Getting it wrong...

“I was shown how to make a hot drink by the occupational therapists and then never allowed to make myself one – so the first time I made a hot drink, I was alone in the house. A little more supervised independence would have been beneficial.”

Getting it right...

“The occupational therapist who visited me was very helpful. She listened to what I wanted to do and arranged visits so that I could try and get back to some of my usual activities. She chased up my aids and gave me hope that things could improve.”

Source: District Audit Rehabilitation Study – Survey of Patients

Box 6: Good practice – leisure co-ordinator

Quantock Rehabilitation Unit, Weston General Hospital

The leisure co-ordinator’s remit is to encourage patients back into normal routines. As well as ward-based activities such as cookery, music and a book club, she also accompanies patients, singly or in a group, on trips outside hospital, such as for shopping or a meal. This in-patient rehabilitation unit has a strong multi-professional ethos, with all staff wearing the same uniform, emphasising the principle that everyone is involved in rehabilitation.
AVAILABILITY OF THERAPY STAFF

Engaging with people takes time. One of the obstacles to a patient-focused approach is the shortage of therapy staff in many areas.

Where therapists are available, they often have little time to engage with individuals. In the community, social services occupational therapists tend to be tied up with supplying equipment rather than providing therapy. The general shortage of therapists in the community means individuals are often left alone to cope.

There is a nationwide lack of speech and language therapists working with older people. Even though more than a third of older stroke patients had communication difficulties, we found very few had access to speech and language therapists for communication problems. As communication is the key to engagement, without speech and language help these people will have difficulty benefiting from any rehabilitation services.

The shortfall in therapy is illustrated by our evidence from staffing data on the levels of physiotherapy made available to patients. The Association of Chartered Physiotherapists’ recommended staffing levels equate to 16 minutes of physiotherapy per bed per day for rehabilitation wards – we found that less than a third of the 600 wards we audited achieved that standard nationally (see Exhibit 3).

While the shortage of therapists remains an issue, trusts could go some way to addressing the problem by making greater use of therapy assistants – though there are mixed views about this approach amongst the professions. Certainly, better planning would allow health agencies and social services to deploy the therapists they have in a way that better meets the needs of older people.
ACCESS TO SERVICES

ACCESS IN THE COMMUNITY

Agencies need to make a fundamental shift, from viewing rehabilitation as a reactive service, to using rehabilitation services proactively to help older people maintain independent lives.

In some cases, the only way for an older person to gain access to multi-professional assessment and rehabilitation services is via admission to hospital. Yet hospital is often the worst place for older people if they are not seriously ill – in unfamiliar surroundings, out of touch with their social networks and with greater risk from infection, they can quickly lose their independence. So people need ready access to multidisciplinary assessment and rehabilitation services in the community.

Many areas have developed community rehabilitation teams. While most schemes are at an early stage of development, they have the potential to bring benefits in future. However, auditors found that, currently, the main barrier to their effectiveness is a patchy and fragmented service (see Box 7).

There are a number of problems with fragmentation:

- Confusion for referrers. At one of our reviews, a survey of GPs found that more than half had poor knowledge of community rehabilitation teams and/or residential rehabilitation services and few had recently referred patients. GPs may find it simpler to admit an older person to hospital than to disentangle the options in the community (see Box 8).

Box 7: A fragmented service

Even where rehabilitation services are relatively well developed, the service can be extremely fragmented. It is not uncommon for staff to rely on pocket cards like those below, with a plethora of contact details for various rehabilitation services.
• Duplication of effort by the various teams
• Ineffectiveness. Some community rehabilitation teams are too small to offer a comprehensive service or a rapid response – integration and rationalisation would make them more effective and would also allow maximum use to be made of therapy staff
• Poor links between day hospitals, community rehabilitation teams and residential rehabilitation centres – there are often vacancies in residential rehabilitation centres despite hospital bed pressures.

ACCESS TO PREVENTATIVE SERVICES

There are many good schemes aimed at preventing stroke and falls among older people. But other preventative services have slipped down the agenda. In general, auditors found little co-ordinated effort to identify vulnerable older people who are beginning to struggle at home and to intervene before a person reaches crisis point and has to be admitted to hospital.

Box 9: Good practice – preventative services

Phoenix Surgery (Cirencester, Gloucestershire)

This NHS Beacon scheme aims to promote independence among the 700 over-75s who use its services. The practice’s Stay Well 75+ Team first sends a postal questionnaire, and follows this with a selective home visit. Comprehensive medical, social and functional care plans are monitored by 28 trained volunteers who befriend older people and give early warnings of problems. A health visitor, working 20 hours per week, supported by an administrative assistant, co-ordinates the team’s efforts.

Carrick Proactive Risk Assessment Project, Central Cornwall PCT

Two elderly care nurses (ECNs) cover practices in Truro, Falmouth, Perranport and St Agnes. The ECNs carry out an assessment of older patients, identifying risk factors as a possible cause or predictor of health and social decline. The aim is to ensure that care needs are monitored and new problems identified early on.

DEVELOPING IMPROVED ACCESS

Older people, their carers and GPs would benefit from simpler and clearer access to rehabilitation services. This could be organised locally in many different ways, ranging from a helpline or information pack, to a single referral point or co-ordinating office, providing a focus for all services that promote the independence of older people, including voluntary services. A more extensive restructuring could involve the merger of existing services, creating a multi-professional core team working with older people in their own homes.

ACCESS IN HOSPITAL

However well developed community services become, many frail older people will continue to access rehabilitation services via hospital. To ensure they receive the care they need and to free up acute medical beds, it is important that patients with rehabilitation potential are transferred to a rehabilitative environment as soon as this is clinically indicated.
There should be systematic processes in place to ensure that all patients with rehabilitation potential are identified on acute wards at an early stage. Referral and transfer arrangements between acute medical and rehabilitation wards need to work effectively to maintain the flow of patients through the system. Some trusts have introduced liaison nurses to manage this process on acute wards (see Box 10, below).

At certain trusts, auditors tested the extent to which referral and transfer arrangements were effective. Our findings raised particular questions:

Are older people receiving the most appropriate treatment?

We found that care of the elderly acute wards, in contrast to other acute wards, had a multi-professional approach which is much better able to untangle the complex medical and social circumstances often presented by older people. This enabled a smooth transition, either to rehabilitation or to a well co-ordinated discharge.

But it is commonly estimated that under half of the frail older patients who would benefit from this multi-professional regime are able to gain access to these wards.

The National Service Framework for Elderly People in England requires that all older people have access to care of the elderly specialists as soon as possible following admission to hospital. This would allow all older patients to benefit from the multi-professional approach and would boost their chances of effective rehabilitation. Many trusts have a long way to go if they are to meet this requirement.

Are rehabilitation wards used to the best advantage?

It is vital that wards intended for rehabilitation are used by those older people most likely to benefit. Auditors found that too often, bed pressures in other wards caused patients without rehabilitation needs to be admitted to rehabilitation wards.

Trusts should use the ward census approach (see Exhibit 4, below) we have developed to track the care pathways for older people, to see whether older patients are receiving the care that will maximise their chances of successful rehabilitation. Dispersal of older patients into too many different wards could prevent them accessing the rehabilitation services they need.

<table>
<thead>
<tr>
<th>Exhibit 4: Example rehabilitation ward census</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehab Ward Census July 2001</strong></td>
</tr>
<tr>
<td><strong>Rehabilitation potential</strong></td>
</tr>
<tr>
<td>Ward</td>
</tr>
<tr>
<td>19</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for the 24 non-rehab patients being on rehab wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why not receiving rehab input?</td>
</tr>
<tr>
<td>Awaiting placement</td>
</tr>
<tr>
<td>Completed rehab, waiting home support</td>
</tr>
<tr>
<td>Transferred for rehab but deteriorated</td>
</tr>
<tr>
<td>Respite care</td>
</tr>
<tr>
<td>Palliative care</td>
</tr>
<tr>
<td>No motivation from patient</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Box 10: Good practice – hospital assessment

West Wales General Hospital

A senior nurse acts as rehabilitation co-ordinator, identifying appropriate patients on acute medical wards for transfer to rehabilitation wards and preventing inappropriate transfers. The nurse’s presence on the wards has heightened staff awareness of the need for early identification of rehabilitation needs.
STROKE CARE

We looked in particular at older stroke patients: if rehabilitation services are not working well for stroke patients, where there is now considerable evidence of the best way to organise services, they are even less likely to be working well for other groups.

Some trusts are well advanced, with acute stroke beds and a stroke rehabilitation unit, together with care pathway documentation and stroke nurse co-ordinators. But in many areas, improved services for stroke patients are still at the planning stage, pending resource bids.

Even where the infrastructure is largely in place, the stroke patient pathway mapping exercise undertaken by auditors raised some concerns:

- Stroke patients can be scattered across a range of different wards on admission
- Many stroke patients spend most of the critical first 72 hours on medical admissions wards, instead of stroke beds
- Many patients who might benefit never access stroke beds.

HELPING AGENCIES MOVE FORWARD

While our reviews identified weaknesses, ultimately our goal is to help agencies work out what action they need to improve rehabilitation services.

In many areas we facilitated a multi-agency action planning workshop (see Box 11). This provided an opportunity not only to discuss the audit findings, but also for managers and practitioners from the various agencies to agree an action plan in particular service areas or localities. Where a workshop was not appropriate, agencies produced their own response to the audit, setting out key actions to be taken. We encouraged agencies to incorporate these actions into existing plans.

“The work will help us to take forward the rehabilitation services for elderly people in Lincolnshire. The action plan is clear and comprehensive, providing an excellent evidence-based plan for Lincolnshire and the audit.”

Lincolnshire County Council
HOW EFFECTIVE ARE YOUR REHABILITATION SERVICES?

If you answer ‘no’ or ‘don’t know’ to any of the questions on this checklist, there are likely to be steps your organisation can take to improve.

1. Do services link together to form a cohesive network, with clear care pathways for older people?  
   - Yes  
   - No  
   - Don’t know

2. Do you have an action plan for increasing co-operation between health and social services, particularly in progressing joint assessment and care planning and joined-up services?  
   - Yes  
   - No  
   - Don’t know

3. Do you have adequate information to inform strategic planning, eg. can you translate population projections into demand for future services?  
   - Yes  
   - No  
   - Don’t know

4. Do you know how central patients (and their carers) are to the rehabilitation process, eg. are they involved in setting objectives and devising care plans?  
   - Yes  
   - No  
   - Don’t know

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**Box 11: Multi-agency workshops – a typical format**

At one recent workshop some 70 delegates from health, social services, housing and the voluntary sector attended. Following a presentation of the audit findings, local managers and clinicians set out the local context, their perspective and response to the audit:

<table>
<thead>
<tr>
<th>What</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrating rehabilitation and intermediate care services</td>
<td>‘Care of the Elderly’ Consultant</td>
</tr>
<tr>
<td>Social services management perspective</td>
<td>Assistant Director of Social Services</td>
</tr>
<tr>
<td>Implementing the stroke national service framework</td>
<td>Consultant Physician (stroke)</td>
</tr>
<tr>
<td>An overview of services for older people</td>
<td>Health Authority ‘Elderly People’ Project Manager</td>
</tr>
</tbody>
</table>

Four action planning sessions, involving all delegates, discussed:

- development of community rehabilitation teams
- proactive identification of vulnerable older people
- managing stroke care in the community
- engaging with rehabilitation patients in their care.

A short report summarising the outcomes of the workshop was circulated the following month and formed the basis of the action plan for agencies to take forward.
5. Do you produce information for GPs and other professionals to raise awareness of the range of services available, eligibility criteria and how to access them?

6. Do you have a plan to tackle any major staff shortages and recruitment difficulties, particularly for therapy staff?

7. Do a high proportion of those older people who would benefit gain timely access to specialist stroke and rehabilitation services following admission to hospital?
   - Is this proportion as high as it should be?

8. Do you know how many rehabilitation ward beds are occupied by non-rehab patients?

9. Do you have standards for having equipment and adaptations in place when a patient arrives home?
   - Are these achieved?

WHO IS DISTRICT AUDIT?

District Audit is the arm’s-length auditing agency of the Audit Commission. As well as issuing an opinion on financial accounts of NHS trusts and local authorities, District Audit undertakes reviews of audited bodies’ corporate governance arrangements and performance management systems.

District Audit is one of the world’s largest public sector auditors, employing over 1,500 staff with a variety of specialist skills to enable us to deliver relevant services to our local government and health clients.

If you would like more information about anything you have read, please contact your District Audit audit manager or contact Business Development on 0121 224 1114 to be put in contact with a specialist.