the way to go home

rehabilitation and remedial services for older people
The Audit Commission promotes the best use of public money by ensuring the proper stewardship of public finances and by helping those responsible for public services to achieve economy, efficiency and effectiveness.

The Commission was established in 1983 to appoint and regulate the external auditors of local authorities in England and Wales. In 1990 its role was extended to include the NHS. Today its remit covers more than 13,000 bodies which between them spend nearly £100 billion of public money annually. The Commission operates independently and derives most of its income from the fees charged to audited bodies.

Auditors are appointed from District Audit and private accountancy firms to monitor public expenditure. Auditors were first appointed in the 1840s to inspect the accounts of authorities administering the Poor Law. Audits ensured that safeguards were in place against fraud and corruption and that local rates were being used for the purposes intended. These founding principles remain as relevant today as they were 150 years ago.

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Website: www.audit-commission.gov.uk
The Role of Rehabilitation
Many people have commented on the need for better rehabilitation services – including the Government.

The Provision of Rehabilitation Services
An integrated range of services is needed that includes inpatient rehabilitation, intermediate care and community services.

Managing the Rehabilitation Programme
People need to follow a clear care pathway, which requires good co-ordination.

Therapists and Rehabilitation Services
The level of therapy can be increased by using therapy assistants and using qualified therapists more flexibly.

Developing a Strategic Approach
A strategic approach requires a shared understanding of what is needed, and a whole-systems approach.
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Preface

The Audit Commission oversees the external audit of local authorities and the National Health Service (NHS) in England and Wales. As part of this function, the Commission is required to undertake studies to enable it to make recommendations for improving the economy, efficiency and effectiveness of services provided by these bodies.

Over the last two years, the Commission has been reviewing rehabilitation services for older people, and its findings are set out in this report. Cross-cutting audits of these services, covering health and social care, will take place throughout England and Wales during 2000 and 2001. For the first time, a single auditor has been appointed to work with all health and social care agencies within local areas.

This is the fourth in a series of reports with the common theme of promoting independence for older people. The other reports in the series have looked at services for older people with mental health problems (Forget Me Not (Ref. 1)), the provision of disability equipment to older or disabled people (Fully Equipped (Ref. 2)) and charging arrangements for home care by local authorities (Charging with Care (Ref. 3)). It follows a previous report The Coming of Age (Ref. 4) published in 1997, which reviewed the health and social care of older people.

In the course of the study, fieldwork has been carried out in 12 areas of England and Wales, with visits to health trusts (acute and community), health authorities and local authority social services. In a few of these areas completely different services were provided in different parts, so that they functioned independently, providing information on up to 16 different sets of services. In the report these data are referred to as ‘Audit Commission study site data’.

The Audit Commission has also carried out a data collection exercise collecting information by authority and trust, and collating some of this information by locality. This report presents the first analysis of these data. These data are referred to as ‘Audit Commission locality data’ in the report.

The study on which this report is based was carried out by Stuart Turnock, Chris Baker and Maggie Kemmner under the direction of David Browning. Data preparation and analysis was carried out by Louise Cloke, Justin Caldwell and Tom Dixon. Particular thanks go to all of our study sites and to Dr Michael Whitelaw and Mary Crawford, professional advisers to the study. Thanks also go to our external advisory group, listed at Appendix 1; and to John Pears of District Audit and Phil Blake who have played a major part in shaping the audit.
The Role of Rehabilitation

Many people have commented on the need for better rehabilitation services, and their comments have been endorsed by government policy. But effective rehabilitation is complex, requiring a range of services, clear care pathways and good organisation.
Introduction

1. Older people are major users of health and social services. Nationally, those aged over 65 make up 16 per cent of the population, but account for nearly one-half of Department of Health (DoH) expenditure and local authority social services expenditure (Ref. 4). The proportion of the total population aged over 65 is set to grow in the coming decades, with three times as many people over 85 estimated by 2050 (Ref. 5). These ‘very old’ people are particularly high users of acute hospitals and other health and social services.

2. Older people tend to suffer from chronic disease and disability: conditions such as stroke, cardio-respiratory diseases and fractured neck of femur all become more common as people age (Ref. 6). They are more likely to benefit from multidisciplinary assessment and rehabilitation. They are also likely to require more time than younger patients to make a full recovery.

3. The Audit Commission’s 1995 report United They Stand (Ref. 7), on the care of people with fractured neck of femur, found that few hospitals organised rehabilitation services well, especially for people who needed more time. In The Coming of Age (1997) (Ref. 4), the Audit Commission drew attention to shortcomings in the way in which health and social services worked together to improve procedures and to develop services that would offer alternatives to unnecessary hospital, residential care or nursing home admission. The Commission found health and social services locked in a vicious circle [EXHIBIT 1, overleaf]. Rising hospital admissions and falling lengths of stay were reducing time for recovery and rehabilitation, and leading to increasing (and unsustainable) demands on social services, especially for residential and nursing home placements. These demands were absorbing resources, reducing funds for community services that could have helped to contain rising hospital admissions.

4. A number of other agencies and bodies have commented on the potential of rehabilitation services – including the DoH, NHS Executive, Social Services Inspectorate (SSI), House of Commons Health Select Committee, Royal Commission on Long Term Care, British Geriatric Society and the King’s Fund.

5. From Government, the comments have been backed by policy statements – in England in the DoH’s executive letter Better Services For Vulnerable People (BSVP) (Ref. 8) published in October 1997. This required health and local authorities to develop rehabilitation services, to improve assessment arrangements and to create joint investment plans (JIPs). A further circular followed – Better Services For Vulnerable People – Maintaining the Momentum (Ref. 9) – which stressed the links between the BSVP agenda and other agendas and national priorities. It emphasised the contribution that rehabilitation can make to the management of demand across the health and social care economy. Authorities were guided to ensure that:
procedures are in place to help them to identify those older people in hospital who are more likely to benefit from focused rehabilitation;

• services are in place that give older people time to recuperate, and enable professionals to work with them on rounded assessments and care plans;

• rehabilitation services, in a variety of settings, are in place to help older people in hospital regain optimum levels of independence and to return home; and

• community-based services are reviewed to help prevent hospital admissions of older people.

In Wales, guidance has stressed the importance of multi-agency planning and there is a high expectation that health authorities and local authorities will work together.

EXHIBIT 1

The vicious circle
Health and social services are locked into a vicious circle.

Pressures on hospital beds are increasing

Admissions to hospital are increasing

People are being discharged sooner

There is less money available for preventive services

There are insufficient rehabilitation services

There is increasing use of expensive residential and nursing home care

Source: Audit Commission
6. Arrangements that allow closer joint working are also being strengthened following the consultation papers *Partnership in Action* (Ref. 10) in England and *Partnership for Improvement* (Ref. 11) in Wales. These papers and subsequent guidance, set out the basis for new flexibilities for funding health and social care to help the development of the integrated services required for good rehabilitation. The *NHS Act 1999* (Ref. 12) now allows pooled funds, lead commissioning and integrated services.

7. In England, the BSVP initiative has been reinforced by other guidance, including *Modernising Health and Social Services: National Priorities Guidance 1999/2000–2001/02* (Ref. 13). In Wales, the *Better Wales* (Ref. 14) consultation paper is proposing to ‘help the elderly and those with disabilities to live independently, and support their carers’.

8. The White Paper *Modernising Social Services* (Ref. 15), published in November 1998, required adult social services to help to promote older people’s independence by ‘providing the support needed by someone to make the most of their own capacity and potential’. This paper has been supported by additional resources between 1999 and 2002 in the form of three specific grants: the Partnership Grant, the Carers’ Grant and the Prevention Grant. Together they provide £747 million.

9. In 2000, a National Service Framework (NSF) for older people is due to be published. The framework is intended to improve the quality of care services and to decrease inequities in health services for older people across the country.

**What is rehabilitation?**

10. A review of *Trends in Rehabilitation Policy* (Ref. 16), commissioned jointly by the Audit Commission and the King’s Fund, concluded that ‘there is widespread confusion about the meaning of rehabilitation, making it difficult at times to distinguish it from other forms of care and support’. This review observed that rehabilitation is ‘often a function of services, not necessarily a service in its own right’. It recognised that while the literature contains a range of ideas and definitions of rehabilitation, there is an emerging consensus that:

- the primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce);
- rehabilitation usually requires a mixture of clinical, therapeutic and social interventions that also address issues relevant to a person’s physical and social environment; and
- effective rehabilitation needs to be responsive to users’ needs and wishes, to be purposeful, involve a number of agencies and disciplines and be available when required.
**What form should rehabilitation take?**

11. A second review, *Effective Practice in Rehabilitation* (Ref. 17) commissioned jointly by the Audit Commission and the King’s Fund, found that although there are gaps in the evidence base, there ‘are positive results for the effectiveness of rehabilitation in a variety of key areas’. The ‘effect sizes that have been shown in these positive reviews are very large and exceed many of those seen with drug treatments’. Four key themes run through the evidence – the need for access, assessment, organisation and continuity.

**Access**

12. Access to rehabilitation needs to be available when required – through appropriate arrangements for assessment and to appropriate services in a range of settings.

**Assessment**

13. There is strong evidence that comprehensive assessment, followed by the implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in long-stay care. It also improves survival rates and physical and cognitive functioning.

**Organisation**

14. The appropriate organisation of services is also critical to their effectiveness. Services should ‘be organised to achieve co-ordination of different interventions and different phases of the rehabilitation process’. Furthermore, the ‘more one can achieve co-ordination of diverse inputs through a systematic approach, protocol or team delivery, the more effective the rehabilitation may be’. The evidence here is particularly strong for stroke care, where there is co-ordinated multidisciplinary care, education, training and the specialisation of staff.

**Continuity**

15. Finally, continuity of care is essential. Where people receiving rehabilitation are transferred between different services, it is essential that their care plan is transferred with them. Services ‘should be organised to achieve co-ordination of different interventions and different phases of the rehabilitative process’. However, managing and delivering this complexity in practice is difficult. It requires a multiplicity of agencies, professions and services to work together, even though they are all funded, managed and held accountable through different means.
Who needs rehabilitation?

16. Everyone who has had an illness or accident needs some time to recover. Most, especially younger people, do not need much help to regain their fitness and take up their lives where they left off. But some, especially older people, need more help, and some will need constant help. Each older person needs an individual response but, broadly speaking, people recovering can be divided into three groups:

- Those who will recover quickly and who do not need more than a limited amount of help with rehabilitation.
- Those who will take much more time and who need a lot more help.
- Those whose recovery will be limited, and who will need palliative or continuing care.

17. The vicious circle [EXHIBIT 1, p6] occurs where members of the second group are treated as if they belonged to the third group. This report focuses on the needs of people in the second group who are aged 75 and over, and looks at how rehabilitation can best be provided for them.

18. Older people who need rehabilitation suffer from a wide range of conditions. Many – perhaps most – suffer from more than one condition. Their needs are often complex. The Royal College of Physicians explains that:

‘Focal disease may have a global impact in a biologically aged patient such that a common and familiar acute condition may present in atypical fashion. An elderly patient with pneumonia may present with the effects of cerebral hypoxia and toxaemia, confusion, impaired mobility and urinary incontinence. The presentation may seem rather unfavourable, with a reversible underlying problem presenting as an apparently irreversible general breakdown. The presence of other concurrent diseases increases the chance of a particular condition leading to dependency and loss of function: so-called “multiple pathology”.’ (Ref. 18)

This, often together with poor economic, social and environmental support, means that the circumstances of older people are often very complex, and illness is frequently associated with acute or chronic disability.

19. To provide some focus, this study has looked at the rehabilitation of people whose primary condition is stroke as a ‘tracer condition’. Stroke has been chosen for a number of reasons. Firstly, it is very prevalent. It is the third most common cause of death in the UK after all cancers and coronary heart disease, and accounts for about one in ten of all deaths. Some 88 per cent of stroke deaths are in people over 65 (Ref. 19). Stroke is also the leading cause of major disability and handicap in the UK, with 35 per cent of survivors still functionally dependent after one year [APPENDIX 2, PART A]. It therefore places a major burden on families and health and social services.
20. Secondly, it is relatively easy to identify and it is recorded using the international classification of diseases (ICD) so that it is possible to use the group of people who have suffered from a stroke as a sampling frame. A survey of such people has been carried out to get their views on the rehabilitation they received [APPENDIX 2, PART B].

21. Thirdly, as reported above, the evidence for the benefits of organised stroke care, including rehabilitation, is now very well established. Patients managed by a specialist co-ordinated stroke team in a stroke unit have lower mortality and morbidity rates and these benefits are achieved at no more cost than managing patients in non-specialist wards and units, according to the Stroke Unit Trialists’ Collaboration (Ref. 20). They have reported a 23 per cent reduction in death, with 60 deaths prevented per 1,000 patients treated.

22. Fourthly, the principles that apply to stroke care can be applied more widely. Effective Practice in Rehabilitation (Ref. 17) recommended that ‘stroke care may be an appropriate model for understanding the efficacy of rehabilitation in other situations’ where several disciplines have a distinctive and complementary role to play and where several inputs need to be co-ordinated. It recommends that the evidence (together with that for assessment) should ‘be translated into routine practice and used to inform rehabilitation developments for other conditions’.

23. The organisation of rehabilitation should match the needs of the people likely to benefit from it. These needs are many and various. However, building on the research described above, a number of broad principles can be set out.

24. A range of services is needed to provide good access to rehabilitation. For people admitted to hospital, rehabilitation starts as part of their acute care. For those who require more time, it may continue on specialist rehabilitation wards, where they remain under the supervision of specialist medical and nursing staff as part of an intensive multidisciplinary rehabilitation programme. Over time, the need for clinical supervision reduces as their medical problems are stabilised, but they may still need help to recover and rebuild their confidence. The need for more intensive therapy support increases, while the need for medical and nursing care reduces, and ‘intermediate care’ between hospital and home may be appropriate. Finally, people at home or who have returned home after hospital, may need access to specialist assessment and rehabilitation from a multidisciplinary team operating in the community. Four main service types are therefore relevant [EXHIBIT 2]. These are discussed in Chapter 2.

25. People need to follow a clear care pathway while receiving rehabilitation. Arrangements need to be in place to screen people to pick up those who need rehabilitation – whether they are at home or on acute hospital wards. Thorough multidisciplinary assessment is then needed, followed by clear care plans and arrangements for delivering care.

How should rehabilitation be organised?
EXHIBIT 2
Rehabilitation services
Four main service types are relevant.

Arrangements are also needed to ensure that rehabilitation programmes continue when people move to another location. All of these arrangements call for good co-ordination and multidisciplinary working, as described in Chapter 3. Therapists are key members of any multidisciplinary team – particularly occupational, speech and language and physiotherapists – and this report considers in some detail in Chapter 4 and Appendix 3 how their contribution is being managed. Finally, all of these various contributions need to be brought together within a plan for delivering better rehabilitation services that makes full use of new policies and opportunities, as described in Chapter 5.
The Provision of Rehabilitation Services

A range of services is needed. In hospital, rehabilitation starts with acute care, but for those who require more time, it may continue on specialist rehabilitation wards and in intermediate care. People at home, or returned home, need the support of a multidisciplinary re-ablement team.
This chapter looks at services whose primary function is the rehabilitation of older people who need more time to recover. Rehabilitation needs a balanced mix of interconnected services. If gaps occur in services in community and intermediate settings, unnecessary hospital admissions may take place. Those admitted may then stay longer than necessary, or be discharged without the support of services to meet their needs at home.

26. This chapter looks at services whose primary function is the rehabilitation of older people who need more time to recover. Rehabilitation needs a balanced mix of interconnected services. If gaps occur in services in community and intermediate settings, unnecessary hospital admissions may take place. Those admitted may then stay longer than necessary, or be discharged without the support of services to meet their needs at home.

27. Assessing the amount of rehabilitation available in any particular locality is difficult. It is provided by a variety of different services in a variety of locations, by a variety of different service providers. The information routinely available about such services and activities is limited. Furthermore, services rarely provide rehabilitation exclusively. General services provide some degree of rehabilitation, while rehabilitation services provide other forms of care, such as treatment for chronic conditions. Many service providers serve different overlapping catchment areas, making it difficult to relate activity to the population served. But some quantification is essential if the planning, management and monitoring of services are to be effective. Many different pieces of a complex jigsaw need to be fitted together to provide an overall picture of the services available in a locality [EXHIBIT 3].

EXHIBIT 3

Services providing rehabilitation

Many different pieces of a complex jigsaw need to be fitted together...
28. Some services are based in hospital, while others provide support and rehabilitation for people at home, or after they have returned home from hospital. In practice, different localities have different combinations of services. During the study, 16 localities were visited (although not all localities provided data on all aspects of care). The patterns of inpatient, intermediate, day and community-based services observed are outlined individually in the following sections. The way they fit together in different localities is then considered.

29. All 16 sites visited provided inpatient rehabilitation beds, although 3 did not provide separate rehabilitation wards, but provided rehabilitation on combined acute/rehabilitation wards. On such wards, staff need to take care that acute needs do not displace rehabilitation needs. The Royal College of Physicians has noted [Ref. 18] that rehabilitation ‘specifically requires different nursing skills and more intensive physiotherapy and occupational therapy input than is available on general wards. Separate rehabilitation wards are needed because in acute wards “the urgent drives out the important…” It is essential, therefore, that certain wards should be set aside where there is nothing more pressing than rehabilitation. These are called rehabilitation wards. In an ideal world all wards would be rehabilitative; in the real world they are not.’

30. The number of beds on rehabilitation wards per head of population varied widely across the ten areas in which full data were collected [EXHIBIT 4]. But the number of beds provides only partial information: the amount of rehabilitation activity is just as significant. The role of the nurse is key. The Royal College of Nursing has identified five areas of activity that registered nurses undertake while helping to rehabilitate older people [BOX A, overleaf]. Because of their presence 24 hours a day on the wards, they are also central to rehabilitation because they co-ordinate the care that older people receive and continue the work of other members of the multidisciplinary team in their absence. However, to do this they need the support and involvement of therapists – particularly occupational, speech and language, and physiotherapists. The availability of therapy to rehabilitation beds varies widely, with some extremely low levels of input in what authorities and trusts are describing as their inpatient rehabilitation facilities. To estimate the intensity of therapy, minutes per bed per day have been calculated (taking out an allocation of time for leave, sickness and training – see Appendix 3, Part B). The resulting figures then represent the maximum level of qualified staff time available per bed and are widely spread [EXHIBIT 5]. Actual input is likely to be lower. Some supposedly intensive rehabilitation services actually have less input available than general care of the elderly wards.
EXHIBIT 4
Inpatient rehabilitation beds at study sites
The level of inpatient provision differs from site to site.

Source: Audit Commission study site data

EXHIBIT 5
Qualified therapy time: available minutes per bed per day for occupational therapy, physiotherapy and speech and language therapy
The maximum level of qualified staff time available per bed is widely spread.

Source: Audit Commission study site data
The framework of the nurse’s role in rehabilitation

There are five types of role functions that the registered nurse engages in while working with older people in a re-enabling way:

- **Supportive functions** include: providing psychosocial, and emotional support; easing transition; enhancing lifestyles and relationships; enabling life review; facilitating self-expression; and ensuring cultural sensitivity.

- **Restorative functions** are aimed at maximising independence and functional ability, preventing further deterioration and/or disability, and enhancing quality of life. This is undertaken through a focus on rehabilitation that maximises the older person’s potential for independence, including assessment skills and undertaking essential care elements (for example, washing and dressing).

- **Educative functions** involve the registered nurse in teaching self-care (for example, self-medication, health promotion, continence promotion and health screening).

- **Life-enhancing functions** include all the activities that are aimed at enhancing the daily living experience of older people, including relieving pain and ensuring adequate nutrition.

- **Team functions** cover the range of administrative and supervisory responsibilities of the registered nurse.

*Source: Royal College of Nursing (Ref. 21)*
31. The amount of therapy available per bed sometimes contrasts with the number of beds available [EXHIBIT 6]. This raises the issue of whether some beds are labelled ‘rehabilitation’, but are used in different ways. For example:

- Authority K appears to have high numbers of rehabilitation beds, but it provides low levels of therapy per bed day.
- Authority C appears to have low numbers of rehabilitation beds, but it provides high levels of therapy per bed day.

The wards with low levels of therapy are not well placed to provide active rehabilitation. Authorities and trusts need to be sure that they are clear about what they are trying to achieve with beds provided for the rehabilitation of older people.

**EXHIBIT 6**

Qualified therapy time per bed compared to numbers of rehabilitation beds

The amount of therapy available per bed sometimes contrasts with the number of beds available.

(Source: Audit Commission study site data)
Stroke units

Rehabilitation for people who have suffered a stroke is best organised on separate stroke units, although 7 of the 16 sites visited did not have them [EXHIBIT 7], and in 1 case that did, there were only 5 beds. Therapy input per bed was consistently high in the five units in which full data were collected [EXHIBIT 8].

Exhibit 7
Study site provision
All had inpatient rehabilitation beds, but not all provided organised stroke rehabilitation through stroke units.

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Note: COMB refers only to sites with combined acute and rehabilitation wards.
Source: Audit Commission study site data

Exhibit 8
Qualified therapy time: available minutes per bed per day for occupational therapy, physiotherapy and speech and language therapy in stroke units
Input was consistently high in the five units in which full data were collected.

Minutes per bed per day

Source: Audit Commission study site data
A further sample from a different set of localities (Audit Commission locality data – see Preface) found stroke units in under three-quarters of them, and the number of beds available for rehabilitation varying by a factor of five [EXHIBIT 9].

**EXHIBIT 9**

**Stroke units**

The number of beds available for rehabilitation varied by a factor of five.

![Beds per 10,000 75+ population chart]

Source: Audit Commission locality data collection
However, many stroke units concentrated on younger people [EXHIBIT 10]. Admissions of people aged 75 or over per head of population varied widely [EXHIBIT 11]. There is nothing in the evidence that suggests that older people should be excluded from organised stroke care.

EXHIBIT 10
Proportion of stroke unit admissions aged 75 or over
Many units concentrated on younger people.

Source: Audit Commission locality data collection

EXHIBIT 11
Stroke unit admissions
Admissions of those aged 75 or over varied widely.

Source: Audit Commission locality data collection
Some areas appear to rely entirely on hospitals to provide rehabilitation. But once people’s medical condition has stabilised, the full range of services available in hospital – whether acute or community hospital – are not always needed, and ‘intermediate’ services can be used instead.

Intermediate services can play a key role, but their purpose has to be clear. The term ‘intermediate’ is often used in a confusing way and is applied at different times to different services, settings or roles. It is used in this report for services that provide rehabilitation between hospital and home. Such services provide rehabilitation to people who are medically stable, but who are not yet ready to return home after their discharge from hospital. They can also be used as ‘step-up’ facilities for people living at home who need a period of intensive rehabilitation, but who do not need the full range of inpatient services with specialist medical and nursing support on site. The key distinction between inpatient rehabilitation services and intermediate rehabilitation services is therefore the presence in the former of specialist clinical support on site. If this is not made clear, there is a danger that given the general confusion around the term ‘intermediate care’, older people will not receive the care that they need. Those who are not medically stable may be discharged inappropriately to a setting without clinical support, or they may be transferred to ‘intermediate’ inpatient beds off the main hospital site – such as those in small community hospitals – without either intensive rehabilitation or specialist clinical care.

The development of intermediate services is somewhat controversial. Some people fear that with the confusion surrounding the concept, older people will be excluded from the appropriate specialist medical and other resources they need, in order to clear hospital beds. In practice, a mixed economy is needed that includes sufficient inpatient rehabilitation services for older people, complete with comprehensive multidisciplinary assessment, specialist medical and nursing input and ‘intensive’ therapy. However, evidence is growing that some older people can also benefit from services whose primary function is to build their confidence to cope once more with day-to-day activities. If such services are to flourish and be as effective as possible, they need to be planned with the full involvement of those providing specialist services. They need to be closely linked to inpatient services to ensure that people are referred appropriately, and have quick access to specialist medical and other support when needed. In short, they should act as an extension to specialist clinical care and rehabilitation, and not as a substitute for it.
One initiative attracting growing attention is the development of social services residential rehabilitation schemes. One-half of the 16 sites visited had established a social rehabilitation scheme. Two have been operating in Devon for several years. Using a short-term stay in a residential setting, the aim is to help frail older people to regain confidence and some of the personal skills lost through acute illness or injury and to avoid unnecessary admissions to long-stay residential or nursing home care.

Local evaluations of both schemes reported some very positive results. People initially considered to be on the threshold of admission to long-stay residential or nursing home care were returning home in high numbers with relatively low levels of support. These findings were endorsed by an audit of both schemes by the SSI and the Audit Commission.

EXHIBIT 12

Study site provision

One-half of the sites visited had established a social rehabilitation scheme.

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Note: COMB refers only to sites with combined acute and rehabilitation wards.

Source: Audit Commission study site data
CASE STUDY 1A

Social services rehabilitation schemes – Exebank, Exmouth (Devon SSD) and Outlands, Plymouth (Plymouth SSD)

Outlands in Plymouth, Devon began operating in 1992 and Exebank in Exmouth in 1995. Both are short-term residential units that were previously local authority residential homes. Outlands focuses mainly on older people discharged from hospital, while Exebank also takes admissions from people living at home, where the GP confirms that hospital care is not required. Funding comes through social services and health. For example, the health service funds the occupational therapists (OTs), physiotherapists, rehabilitation assistants and a designated community nurse at Exebank. Additional services are available to Exebank through the local re-ablement team – speech therapist, continence advisor and clinical psychologist. There are 19 beds at Exebank and 23 at Outlands. The average length of stay is just over 29 days at Exebank and 42 days at Outlands.

During the pilot stage of the Outlands project, 42 people were discharged home during a six-month period in 1992/93. While in hospital, all had been assessed as definitely needing admission to residential care. At the time of the pilot, dependency was measured against a core assessment format (assessing mobility, personal care, etc) and showed an average improvement of 28 per cent when people were discharged home. A follow-up exercise was carried out from March to June 1997. Of the 42 people, 22 had died (often after quite lengthy periods at home) but only 4 had been admitted to residential or nursing home care during the 5 year period (Ref. 22). Finally, levels of ongoing domiciliary care at home were found to be low. In addition a separate telephone survey of 90 users in July 1995 indicated that 45 per cent did not need continuing social care support. The SSI estimated that an average ongoing home-care package cost about £50 per week.

Similarly, monitoring data at Exebank showed that of 105 admissions in 1996, 86 per cent were admitted from hospital. At the point of referral, 24 per cent were assessed as having the potential to return home, but once the rehabilitation programme was completed, over 71 per cent actually went home (Ref. 23).
While the overall evidence showed that the schemes were successful, some important issues were raised. Firstly, a high number of people (nearly 40 per cent) going through the schemes were not considered to be on the threshold of admission to long-term care when initially admitted. While these people may well have benefited from the services, the schemes were specifically set up for people on the threshold of long-term care. Their presence within the schemes in such high numbers shows how easy it is for services to shift from their original aims and purpose. If planned and understood, such a shift is fine. If not, people who are on the threshold of admission to long-stay care may be denied access. Such services need to be continually monitored and evaluated to ensure that people receiving care meet the eligibility criteria, and that the aims and objectives of the schemes are being achieved.

CASE STUDY 1B
Audit Commission/SSI audit of two social services rehabilitation schemes – Exebank, Exmouth (Devon SSD) and Outlands, Plymouth (Plymouth SSD)

The audit was designed to provide information on three questions:
- Are the schemes taking people who would otherwise have been admitted to residential or nursing homes?
- Do such people return home?
- For those who do return home, is the result long term?

Method
Given that Outlands and Exebank operate to the same overall aims, the two settings were considered together. A 20 per cent systematic sample of clients was drawn from a full chronological list of discharges from both units for the period 22 April 1996 to 21 April 1998. The sample was stratified so that 20 per cent of the discharges were drawn from each unit, providing 70 discharges from Outlands and 49 from Exebank, or 119 overall.

Casefiles of the sample of clients were reviewed and information drawn from them to ascertain:
- whether there was sufficient evidence that the client had been on the threshold of admission to residential or nursing home care (final judgement lay with the SSI inspector); and
- the care package provided at the time of discharge.

Findings
It was judged that 72 out of the 119 users (60.5 per cent) had been on the threshold of entering residential or nursing home care when they entered these schemes. Of these 72 cases, 1 had died and 1 had withdrawn from the scheme, while 16 were admitted to a residential/nursing home or hospital. A statistical analysis showed that the effect of the scheme is real at the point of discharge.

The effect of the scheme was found to be lasting and people discharged were still significantly independent on follow-up at 1 March 1998.

Ideally, the scheme should have been assessed prospectively using a randomised control trial or a matched-pair sampling methodology. Users would either have been allocated to the scheme (test group), or to a comparison scheme (control group). The outcomes for each (randomised or matched pair) group of users could then have been compared. Such an approach was not possible in the time, but the audit did provide useful information about the operation of the schemes.

40. While the overall evidence showed that the schemes were successful, some important issues were raised. Firstly, a high number of people (nearly 40 per cent) going through the schemes were not considered to be on the threshold of admission to long-term care when initially admitted. While these people may well have benefited from the services, the schemes were specifically set up for people on the threshold of long-term care. Their presence within the schemes in such high numbers shows how easy it is for services to shift from their original aims and purpose. If planned and understood, such a shift is fine. If not, people who are on the threshold of admission to long-stay care may be denied access. Such services need to be continually monitored and evaluated to ensure that people receiving care meet the eligibility criteria, and that the aims and objectives of the schemes are being achieved.
Secondly, the Devon schemes and their success need to be understood in the context of the local arrangements. The schemes are well integrated into the range of other rehabilitation services available in the locality, and a number of systems and processes support their success. In both areas of Devon there are a range of well-developed and integrated rehabilitation services across health and social care. Particularly important are:

- a clear set of arrangements for gatekeeping and accessing the service, which is linked with, and related to, all other rehabilitation services in the area and in both cases, the local consultant geriatricians are closely involved with the schemes;
- a range of rehabilitation services available to support people after discharge from the social rehabilitation scheme, provided by the local re-ablement team; and
- a record of evaluation of the schemes (monitoring is particularly well developed at Exebank), so that the services are continually reviewed and refocused as appropriate.

Thirdly, it is important that such schemes are properly planned. A recent seminar (Ref. 24) involving staff from intermediate rehabilitation schemes that had been running for some time identified some of the factors that are important when establishing and running such schemes:

- create a separate therapeutic physical environment;
- involve appropriate staff (OTs, physiotherapists and care staff) to create a therapeutic approach through a dedicated team;
- plan a sustainable catchment area (important when linking to GPs and primary care);
- have an appropriate number of beds planned in the context of other rehabilitation services for older people in the area;
- support staff through appropriate training and team building;
- have clear eligibility criteria and gatekeeping protocols (particularly checking that information is available on prognosis, medical stability and motivation);
- promote the service so that staff in all agencies understand its role and focus;
- involve users and carers in the rehabilitation programme by sharing and agreeing goals; and
- have clear information about charges for users.

Schemes established by other authorities are now also reporting encouraging findings from early evaluations. For example, a recently established scheme in Rotherham has been evaluated by the University of York Health Economics Consortium [CASE STUDY 2, overleaf]. The scheme achieves similar rates of return home to the Devon schemes and the evaluation concludes that ‘the scheme is cost effective for the NHS and Social Services’.
CASE STUDY 2

Rotherham – residential rehabilitation scheme

Rotherham has used short-stay residential home places with intensive therapy input, both as a step between acute hospital and home, and to prevent admission to hospital. The scheme is modelled on the ‘Outlands’ project in Devon. It was established in surplus accommodation in Broom Hayes, part of Rothwell Grange, a social services residential home. Initially, the scheme had six places, but was subsequently extended to nine. The facility is managed by social services but additional therapy staff have been provided by the NHS. Based on a multidisciplinary assessment of individual need, the aim of the unit is ‘to provide therapy, care and support to enable older people to achieve their maximum level of independence’. Residents need to be medically stable. Intensive residential rehabilitation is provided for a maximum of six weeks. On discharge, the progress of residents who return to their own homes is monitored over a six-month period.

The cost of the scheme is shared between health and social services. The NHS meets the costs of physio and occupational therapy and the overall management of the scheme. Social services meet the cost of a hospital-based social worker, scheme-based social workers and day-to-day unit running costs, including care staff.

The scheme has been evaluated by the University of York Health Economics Consortium (Ref. 25). A total of 50 patients were admitted to Broom Hayes in the first 9 months of operation, with 34 rejections after assessment. Of those admitted, 82 per cent were 75 or above (50 per cent were 85 or over). Only one person was under 65. Of those admitted, 80 per cent lived alone. Almost two-thirds of assessments were undertaken on a hospital ward and one-third in people’s own homes. Almost all assessments were undertaken by two or more professionals (82 out of 84). A physiotherapist was involved in 93 per cent of assessments, an OT in 82 per cent and a social worker in 60 per cent.

The average length of stay was 22 days and only 2 patients stayed beyond 6 weeks. Patients were assessed against a dependency scoring system on admission and at discharge. The profiles of the dependency scores indicated that the majority of improvement was achieved within the first four weeks with some requiring less time to restore their independence. This indicates ‘the importance of having individual plans for each resident rather than a standard period of residence for everyone’ (Ref. 25).

In total, 39 people out of 50 (78 per cent) were discharged home, with only 3 needing admission to long-term care, while 8 had to be admitted or re-admitted to hospital. Of those discharged home, 76 per cent received at least one community service, 46 per cent received two or more services and 18 per cent at least three services.

Six months after discharge, 71 per cent of those discharged home were still at home.

The evaluation concluded that the scheme is cost effective for the NHS and Social Services. At 70 per cent occupancy ‘the average cost of the NHS therapeutic input is £529 per patient, which is equivalent to about 4 inpatient days at £125 a day’. Assuming that Social Services would need to meet two-thirds of the weekly cost of 24-hour residential care and that three-quarters continue to return home, the break even point occurs for Social Services after recipients have been in the community for between 13 and 18.5 weeks (based on 70 per cent and 50 per cent occupancy levels respectively). Therefore, the scheme has the potential to generate significant cost savings for Social Services.
Another recently established scheme in North Yorkshire also reports a high rate of discharge home for frail older people who, on admission, were assessed as needing long-term care. Again, the initial calculations of the financial, as well as human benefits, are encouraging [CASE STUDY 3].

CASE STUDY 3

North Yorkshire pilot social rehabilitation scheme – Scarborough

All 63 admissions to the unit during the first few months of 1999 were assessed as ‘requiring some form of residential care’. The average length of stay on the unit was 22 days. Of the 63:
- 7 had to be re-admitted to hospital;
- 6 were discharged to residential or nursing home care; and
- 50 were discharged home.

Of the 50 who were discharged home:
- 30 did not need any services in November 1999;
- 13 received ‘low’ packages of care (typical net cost £50 a week); and
- 7 received more expensive packages of care (£75 to £266 net cost a week).

This means that initial net savings (after the costs of the rehabilitation and ongoing community services) of an estimated £41,000 have been achieved, compared with the equivalent cost of independent residential care costs. The scheme is to be closely monitored to see if the benefits can be sustained over the longer term.
These social rehabilitation schemes provide similar levels of qualified therapy to residents to those provided within health settings [EXHIBIT 13]. They also use therapy assistants to increase therapeutic activity. For people who are medically stable and not in need of specialist nursing care, such schemes can be an important way to obtain continuing access to therapy in a caring environment.

This is all achieved at relatively low cost. The costs of social rehabilitation units are about one-half of those of community hospitals according to research commissioned for the study, looking at the rehabilitation pathways and costs of patients with a fractured neck of femur [BOX B]. The research has shown that length of stay dominates the total costs. Patients who are transferred to either a community hospital or social rehabilitation scheme have a longer overall length of stay and thus total costs are higher, than those who remain in acute care, despite higher daily costs. This reiterates the importance of ensuring that the use of intermediate settings is appropriately targeted at those who would otherwise be unable to return home.

EXHIBIT 13
Qualified therapy time: available occupational therapy and physiotherapy minutes per bed per day in social rehabilitation schemes.

Social rehabilitation schemes provide similar levels of therapy to residents within health settings.

Source: Data from the Rotherham, Plymouth and Exmouth schemes
Being ‘social’ rehabilitation schemes, run by local authorities, users were charged for their short-term residential stay. However, these data show that users were accessing NHS-funded and provided therapy in a caring and homely environment. In the light of this, the issue of charging needs to be reviewed, if such schemes are to develop and play as effective a role as they could.

**BOX B**

**Rehabilitation Pathways for Older People. Research into pathways and costs. Nuffield Institute for Health, University of Leeds, with the University of York** (Ref. 26)

The Audit Commission commissioned research from the University of York with the Nuffield Institute for Health at the University of Leeds to look at rehabilitation pathways for older people, using fractured neck of femur as a tracer condition. The research investigated the experiences of people and the costs of care at four sites. The research found that the rehabilitation inputs varied between sites and individuals, even between people with apparently similar levels of need.

The use of community hospitals was not always justified in relation to the need for specialist medical cover through a period of recovery. Those in hospital on some sites were at similar levels of need to those in other sites who were discharged into other models of care – for example, social rehabilitation units. This is despite costs of £59 a day net (£66.50 gross) for an actual scheme compared to community hospital costs of £123 a day. For example, in one area (of three reviewed) people were placed in each type of care depending on where they lived rather than by need. The research also found that those transferred to a community hospital received lower therapy input than those transferred to social rehabilitation units.

The environment within some community hospitals and all the social rehabilitation units was felt to be more homely by users, and the attitude of staff more tolerant of higher levels of need than in acute wards. People were very complimentary about their treatment in social care settings.

*Source: Nuffield Institute for Health, University of Leeds, with the University of York (Ref. 26).*
Day and community-based services

48. Day hospitals are available in many areas and are seen as a resource for assessment and rehabilitation. Community-based assessment and rehabilitation services need to be available to:

- help avoid admission to hospital in situations where appropriate assessment and care can be provided in the community; and
- provide assessment, rehabilitation and review in people’s own homes.

49. Once again, it is important that people are clear about the focus and role of services. Nearly all of the sites visited had a day hospital, but only just over one-third had a multidisciplinary team providing assessment and rehabilitation in the community [EXHIBIT 14].

50. Audit Commission locality data also indicate that a day hospital is available in 80 per cent of localities and access to multidisciplinary teams in 50 per cent. However, again, this is only part of the story. The absence of intermediate and community-based services in many areas in the past has meant that day services, particularly day hospitals, have been the only resource for accessing multidisciplinary assessment, rehabilitation and review outside an inpatient setting. However, day hospitals are used in many different ways, and reviews have indicated that some are not used well because of poor co-ordination, inadequate transport arrangements and poor overall use of time. They are relatively expensive and people spend a lot of time travelling to them.

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EXHIBIT 14

Study site provision

Nearly all of the sites visited had a day hospital, but only just over one-third had a multidisciplinary team providing assessment and rehabilitation in the community.

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Note: COMB refers only to sites with combined acute and rehabilitation wards.

Source: Audit Commission study site data

30
Access to day hospitals and home-based teams by older people varies by locality. The number of new users aged 75 or over accessing day hospitals varies by more than a factor of ten and by even more for home-based multidisciplinary rehabilitation [EXHIBIT 15]. The result is different patterns of use – some focus on reviews while others focus more on active rehabilitation. Again, this is fine as long as people are clear about their role and purpose within the wider range of rehabilitation services.

**EXHIBIT 15**

**Number of new users aged 75 or over per 10,000 population aged 75 or over**

The number of new users aged 75 or over varies more than tenfold for day hospitals... 

... and by significantly more for home-based multidisciplinary rehabilitation.

*Source: Audit Commission locality data collection*
Community rehabilitation, starting from a low base, has been growing rapidly. A recent postal survey of 98 community rehabilitation teams by Professor Pam Enderby of Sheffield University (Ref. 27), has found that many do not have representatives from key professions. The majority have some physiotherapy and OT input, but there are significant gaps from other professions [EXHIBIT 16]. Physiotherapy was available to 94 per cent of teams and occupational therapy to 92 per cent, but nursing input was available to only 43 per cent, speech and language therapy to only 39 per cent and medical input to only 27 per cent. Indeed, in many cases, the teams were no more than community therapy teams rather than full multidisciplinary rehabilitation teams. This is not to say that they do not provide a useful service, but they further reflect the confusion surrounding the nature of rehabilitation services, especially given that the survey found that 58 per cent of teams were developed to facilitate early discharge, 29 per cent were to help close hospital facilities, and only 13 per cent were an ‘additional service development’. Commenting on this, Professor Enderby noted that nursing and medical involvement were key to the service being replaced, but in nearly all cases they were not included in the community team. In addition, more than 50 per cent of teams had time-limited funding and their future was not secure.

EXHIBIT 16
Multidisciplinary involvement in community rehabilitation teams
The majority have some physiotherapy and occupational therapy input, but there are significant gaps from other professions.

Source: Professor Pam Enderby: A survey of community rehabilitation teams (Ref. 27)
A clear purpose, and the staffing to meet that purpose, are essential. In Rotherham, a Community Assessment Rehabilitation and Treatment Scheme (CARATS) has been developed. Part of its purpose was to provide a rapid response scheme in the community to prevent avoidable admissions to hospital, reduce lengths of stay in acute hospital care and prevent inappropriate admissions to residential and nursing homes. By being clear about the role and purpose of the scheme, and linking it to other initiatives, independent evaluation has shown that considerable benefits have accrued [CASE STUDY 4].

CASE STUDY 4
Rotherham – Community Assessment Rehabilitation and Treatment Scheme (CARATS)

Between 1990/91 and 1994/95 Rotherham Acute Trust experienced a 32 per cent growth in emergencies and an 85 per cent increase in admissions through A&E. A review of inpatient and other facilities in general medicine and medicine for the elderly (Ref. 28) showed that an additional 14 beds were required. Predicted demographic change suggested that the Trust would need another 29 beds (ie, another ward) by the year 2000 unless alternatives to hospital care were developed locally. The response was to develop a Community Assessment, Rehabilitation and Treatment Scheme (CARATS) in 1997, using money from the Continuing Care Challenge Fund. CARATS was developed by local NHS and social services organisations to:

- prevent avoidable admissions to hospital;
- reduce lengths of stay in acute hospital care;
- prevent inappropriate admissions to residential/nursing home care;
- devolve care assessment and management of these patients to the primary care team; and
- help to identify local community care needs.

Initially, the scheme was made up of two major elements:

- a ‘fast response service’; and
- residential and day rehabilitation schemes.

The University of York Health Economics Consortium has evaluated both (Ref. 25).

The rapid response team received 644 referrals in its first 15 months of operation, with 406 being accepted. Approximately twice as many accepted referrals were to prevent admission than to facilitate discharge, and increasing numbers of assessments were undertaken in the community. Terminally ill patients accounted for about 40 per cent of accepted referrals. Only 8 per cent of patients had to be admitted to hospital while in receipt of CARATS. Considerable numbers of bed days have been saved (1,684–2,880 depending on assumptions about length of stay), at a lower cost per bed day.

In addition to the two major elements of CARATS, other schemes have been developed. These have included:

- the provision of therapy (physio- and occupational therapy) to a social services day centre to complement the social rehabilitation scheme; and
- the use of nursing home beds for recovery. These were for patients who no longer required hospital-based medical care but who needed a maximum two-week period of nurse-supported care and recovery before returning home. They were also used to prevent hospital admission for people whose carer had fallen ill.

In addition, other developments are being planned as there is still considerable potential to improve the schemes further and to extend the range of care provided in patients’ homes.
In Sheffield, a well established set of community rehabilitation teams (CRTs) have been developed [CASE STUDY 5]. While based in the community, they have good links with acute care and local inpatient rehabilitation services and have access to intensive home-care nursing.

The most critical element often missing from community-based approaches is full and speedy access to medical assessment and care, linked to all the other multidisciplinary inputs. A full multidisciplinary approach to community-based rehabilitation has been taken in North Devon with the development of community re-ablement teams [CASE STUDY 6A].

CASE STUDY 5

Sheffield community rehabilitation teams (CRTs)

Two community rehabilitation teams (CRTs) were established in 1995 in Sheffield as a partnership between the community health trust and the two acute trusts to provide therapy within patients’ homes. They were established as part of a reconfiguration of services and as a direct alternative to multidisciplinary therapy in hospital. A third and a fourth team were established in January 1999. The CRTs now cover all patients who have a GP in Sheffield.

There are two teams covering the north of the city and two covering the south. Core membership comprises two physiotherapists, two OTs, generic therapy assistants, a speech and language therapist, and administrative/clerical staff. There is a dedicated social worker and psychologist covering all four teams. There are two team leaders; a physiotherapist covering the two northern teams and an OT covering the two southern teams. Access to 48 hours of intensive home-care nursing is available. The CRT has its own equipment store, and team members can visit patients on the day of discharge.

Team working is aided by weekly meetings to set and review joint therapy and patient goals. Team members also meet up at the beginning and end of each working day. Patient-held records are also maintained. CRT members treat patients for up to three months and will visit and review the patient three months after discharge. Each team can treat approximately 22–25 patients at any one time depending on case mix.
Evidence suggests that the re-ablement model is proving successful in meeting its objectives. It is making a major contribution not only to the delivery of well-managed, co-ordinated assessment and rehabilitation, but to the management of demand across the health and social care economy. Two similar general practices in the area have been compared – one with access to re-ablement and the other without access [CASE STUDY 6B, overleaf]. The practice with access has seen a fall in emergency admissions for people over 75, in length of hospital stay and the percentage of re-admissions while the other has seen a rise in these measures [EXHIBIT 17, overleaf]. Overall, the Northern Devon Healthcare Trust reported a 12 per cent drop in emergency admissions at a time when most others are experiencing a rise.

CASE STUDY 6A

North Devon Re-ablement Teams

The reablement service provides multidisciplinary rehabilitation in the community to all people over 16. Partnership Grant monies have been used to fund social services staff. Social re-ablement beds are also available.

Currently, there are four teams – based in Ilfracombe, Barnstaple, Bideford and Holsworthy. A fifth team is planned for South Molton.

The aims of the re-ablement service are to:

- reduce the number of unavoidable emergency and unplanned admissions and re-admissions to hospital;
- ensure people are discharged from hospital in a timely and effective manner;
- reduce the number of long-term placements in residential and nursing care by 20 per cent per annum; and
- ensure that the services provided to maintain people at home are well targeted and effective.

Referrals can be made by anyone. The teams have physiotherapy, occupational therapy, speech and language therapy, nurses, medical sessions, support workers/community care workers, a social worker, a co-ordinator and administration/clerical support. In addition, the team provides access to a psychologist, dieticians, a chiropodist, primary care services and a volunteers’ co-ordinator.

Admission to the re-ablement beds for a planned maximum of six to eight weeks allows proper assessment of needs and appropriate planning. These beds may be needed where:

- a carer becomes incapacitated and there is no immediately obvious replacement and the patient is at risk or at potential risk;
- any incident at home renders it unsafe for the person to stay at home; and
- an acute problem occurs but it is not appropriate to admit to hospital. However, there may be a short-term increase in care needs due to loss of confidence or increased physical need in the short term.
Community re-ablement contributes to the delivery of well-managed, co-ordinated assessment and rehabilitation...and...to the management of demand across the health and social care economy.

CASE STUDY 6B

North Devon Re-ablement Team – key success data

Details on the North Devon Re-ablement Teams have been given in Case Studies 6A (location, staffing and aims), 9 (key worker system) and 10 (team working). There is encouraging evidence that the teams are delivering outcomes in line with the aims and objectives. In doing so, the re-ablement service is making a major contribution not only to the delivery of well-managed, co-ordinated assessment and rehabilitation, but to the management of demand across the health and social care economy.

To evaluate the impact of re-ablement two general practices of equal size and demographic composition were compared.

<table>
<thead>
<tr>
<th></th>
<th>Practice A</th>
<th>Practice B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of GPs</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Number of community hospital beds</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Number of nursing beds</td>
<td>165</td>
<td>177</td>
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<tr>
<td>Number of residential beds</td>
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<td>413</td>
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<tr>
<td>Total number of patients</td>
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<td>7723</td>
</tr>
<tr>
<td>Total number of patients aged over 75</td>
<td>840</td>
<td>758</td>
</tr>
<tr>
<td>Total number (percentage) of patients aged over 75</td>
<td>9.5%</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

Practice A had access to re-ablement from 1994, whereas Practice B did not have access until 1999. Data for those aged over 75 were collated and compared for 1992 (when neither had access to re-ablement) and for 1998 (when Practice A had had access to re-ablement for over three years). This covered emergency stays in hospital, the average length of stay for patients admitted, the re-admission rate and occupied bed days. The comparison shows an improving pattern for practice A with access to reablement and deterioration for practice B without access [EXHIBIT 17].

Between 1992 and 1998, Practice A with re-ablement saw a reduction for the over 75s in emergency admissions, in length of hospital stay and the percentage of re-admissions. Conversely, Practice B saw an increase for the over 75s in emergency admissions, in length of hospital stay and the percentage of re-admissions.
EXHIBIT 17
Comparison of two similar general practices

The practice with access to re-ablement has seen a fall in emergency admissions, re-admissions and lengths of stay while the other has seen a rise.

Source: Data from North and East Devon Health Authority and Northern Devon Healthcare Trust

Day care can also be used to provide rehabilitation. At the Oaks Resource Centre in Bradford, therapy is used to help older people keep their independence and live in their own homes in the community for as long as possible [CASE STUDY 7, overleaf].
CASE STUDY 7

Bradford – The Oaks Resource Centre (Keighley)

The Oaks is a day centre run by Bradford Social Services offering social day care, therapy and support to older people in Keighley and surrounding areas of West Yorkshire. The centre aims to help people to keep their independence and live in their own homes in the community for as long as possible.

A range of services is jointly provided by Bradford Social Services and Airedale NHS Trust, including 15 places per day for older people who need physiotherapy and occupational therapy as part of their rehabilitation following injury or illness. The building has a new fully equipped occupational therapy and physiotherapy department. A range of other services is also available including bathing, chiropody and counselling. Those attending have care programmes drawn up in full discussion with both themselves and their carers. The programmes are reviewed regularly. Each person has a ‘key worker’ who is responsible for co-ordinating their care. Once the care programme has been completed, a review is held to decide whether further rehabilitation or day care is needed.

Currently, the centre is only open on weekdays but funding is being sought to extend the opening hours to weekends.
Linking services

58. So far, individual services have been described. However, such services should not exist in isolation, but be part of a whole system. In most areas, the services reflect historical rather than planned development, producing very different patterns overall, with significant gaps in the services available in some areas [EXHIBIT 14, p30]. A first important link is that between initial ‘acute’ care and inpatient rehabilitation. Although all sites had inpatient rehabilitation beds, the type and location of those beds varied [EXHIBIT 18]. Eight had rehabilitation beds on the acute site, with three having combined acute and rehabilitation beds. Five had rehabilitation beds provided on a different site, and two had provision both ‘on’ and ‘off’ site. This has particular significance to the management of patient pathways as discussed in Chapter 3.

59. The diversity in the range of services available and the overall arrangements at different sites can be illustrated by showing the very different service configurations in four areas.

EXHIBIT 18
Type and location of rehabilitation beds
The type and location of rehabilitation beds varied.

Source: Audit Commission study site data
In Area A, services are quite limited and there are significant gaps [EXHIBIT 19]. After acute care, inpatient rehabilitation beds are available on the same site in two wards of 20 beds with some access to a high-dependency unit off site. There is no stroke rehabilitation unit. A limited amount of rehabilitation is available in two intermediate settings, provided by a nursing home and social services. There is a day hospital available for follow up and therapy. There are no community-based therapy services available for people in their own homes.

EXHIBIT 19
Rehabilitation services for older people in Area A
Services are quite limited and there are significant gaps.
61. In Area B, services are more extensive than in Area A, but there are some gaps, particularly in intermediate and community services [EXHIBIT 20]. There is a high number of options immediately after acute care with inpatient rehabilitation beds on other sites. Although immediate acute stroke care is spread across all general medical wards, there is a stroke rehabilitation unit. There are adult general rehabilitation and elderly care rehabilitation beds, and a specific orthogeriatric facility. All of these are hospital based with specialist medical and nursing input available. There are no intermediate facilities for those who require therapeutic input but not specialist medical or nursing input on site. There is no social rehabilitation unit. There is a day hospital and community-based physiotherapy and occupational therapy, but no access for older people to the full range of services required for community-based multidisciplinary assessment and rehabilitation.

EXHIBIT 20
Rehabilitation services for older people in Area B
Services are more extensive than in Area A but with some gaps particularly in intermediate and community services.

Source: Audit Commission study site data
62. In Area C, services are quite developed, with an increasing range of services available in the community [EXHIBIT 21]. Acute and intensive rehabilitation services are provided from the same site with a well-differentiated set of ‘intensive’ rehabilitation services, provided under specialist medical and nursing cover. These include separate wards for stroke rehabilitation, orthogeriatric rehabilitation, and the rehabilitation of frail older people in general rehabilitation wards with other adults. There is also a ward, under the supervision of a geriatrician, that prepares older people who are going to need to enter long-term care, following a full multidisciplinary assessment. There is a social rehabilitation unit available in one part of the city, but no other significant ‘intermediate facilities’. There is a day hospital and a well-developed set of multidisciplinary community rehabilitation teams, with social services involvement, working in older people’s own homes.

EXHIBIT 21
Rehabilitation services for older people in Area C
Services are quite developed and there is an increasing range of services available in the community.

Source: Audit Commission study site data
63. In Area D, services are well developed and integrated, with a significant involvement by both social and health services [EXHIBIT 22]. After acute care there is a stroke rehabilitation unit off site and elderly care rehabilitation wards all providing rehabilitation services under specialist medical and nursing care. There is also a well-developed range of ‘intermediate’ services for those who are medically stable but who require more time, care and therapy to recover fully. These include a social rehabilitation unit and other health units all with a clear purpose. Finally, day and community rehabilitation services are well developed, with a day hospital, a rapid response team and a community re-ablement team. The re-ablement team is critical. As well as providing multidisciplinary care in people’s own homes, it is available to work with patients in the intermediate settings, providing reliable and quick access to specialist medical and other input where necessary.

**Conclusion**

64. All areas have some rehabilitation services, but most have gaps. Services have been developed in isolation, and need to be reviewed together. They also need to have clear links between them, and this is the subject of the next chapter.

EXHIBIT 22
Rehabilitation services for older people in Area D
Services are well developed and integrated with a significant involvement by social services and health.

Source: Audit Commission study site data
The Provision of Rehabilitation Services

1. Authorities and trusts need to be clear about the role and nature of inpatient rehabilitation beds provided for older people.

2. Trusts that do not have stroke units should be setting them up in accordance with the research evidence.

3. Authorities need to consider establishing intermediate rehabilitation services, integrating them into the range of other rehabilitation services.

4. Community-based assessment and rehabilitation services are needed to support people in the community, but teams need to be clear about their purpose and be staffed accordingly.

5. Individual services should not exist in isolation, but be part of a coherent whole.

6. Agencies in each area need to review the overall pattern of services and work out whether some reconfiguration is desirable.
Managing the Rehabilitation Programme

People need to follow a clear care pathway while receiving rehabilitation. These arrangements require good co-ordination and multidisciplinary working.
Effective organisation and co-ordination of the rehabilitation programme is crucial. Many older people who require help have a number of problems – possibly more than one medical condition requiring lots of different drugs (multiple pathology and polypharmacy). Many have a physical disability and a high number have dementia. A proportion have difficulties with their social and environmental support.

If older people’s level of functioning is to be restored to the maximum extent possible, a whole range of needs will have to be addressed. For some people, the process will be complex and time consuming, and will involve a range of different services provided by different professionals and organisations. This chapter examines the arrangements needed to make this happen, looking first at the care pathways that need to be in place, and then at how staff need to work together to use these pathways to best effect.

People who need intensive rehabilitation need to follow a clear pathway that involves screening, assessment, care planning and good continuity when transfers occur between services.

**Care pathways**

**Screening**

The first stage of the process is to identify the people who need an intensive programme of rehabilitation. An effective screening process is required to identify them either on the wards or at home. Without good screening systems, wrong decisions become more likely. On busy acute wards, older people’s needs can be missed in the constant pressure to discharge or transfer patients as quickly as possible. They may be considered ‘safe’ to be discharged home, or to require a residential or nursing home placement before a proper assessment of their rehabilitation potential has been made. Alternatively, pressure to free up beds may lead to patients being transferred to an available bed on a rehabilitation ward inappropriately, while they are still too ill to be able to participate in active rehabilitation.

The screening of older people’s needs for rehabilitation is particularly important where they are admitted to general wards throughout the hospital and integrated with younger people. Greater integration can have positive benefits, but it can also mean that people who would benefit from ‘concentrated’ care by a specialist team – people who have had a stroke, for example – are not easy to reach. Of the hospitals studied, one-third concentrated acute care for stroke patients in a defined set of beds or wards. The other two-thirds admitted stroke patients to a wide range of locations throughout the hospital. Direct comparison of the distribution of stroke patients three days after admission in two different hospitals illustrates this point. Where stroke patients tended to be concentrated in Hospital A, they were admitted across 16 different wards in Hospital B – making concentrated stroke care difficult and the need for effective screening critical [EXHIBIT 23].
Comprehensive assessment... reduces the risk of older people being re-admitted to hospitals or placed in care homes.

70. A screening form developed in Sheffield helps staff to identify people who need more thorough multidisciplinary assessment [CASE STUDY 8, overleaf]. In Bradford, the stroke unit, which operates on a different site from that used for acute medical admissions, employs ‘liaison nurses’ who ‘case find’ and carry out pretransfer assessments following an agreed protocol for admission to the stroke unit [CASE STUDY 11, p60].

Assessment

71. Once people who could benefit from intensive rehabilitation have been identified, they then need a multidisciplinary assessment. There is strong evidence that a comprehensive assessment, followed by the development and implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in care homes. It also improves people’s survival rates and their physical and cognitive functioning (Ref. 29). Comprehensive geriatric assessments reduce death rates by 35 per cent and subsequent admissions to hospital by 12 per cent (Ref. 30). Effects of this magnitude are greater than those seen for many accepted drug treatments (Ref. 17). Assessment is crucial to the overall success of the rehabilitation process.

EXHIBIT 23
Location of stroke patients aged 75 or over 3 days after their stroke
Hospital B had stroke patients on 16 different wards.

Source: Audit Commission stroke case analysis
The processes of screening and assessment are far from systematic, however. Evidence continues to grow that exclusion from rehabilitation services is producing more admissions to residential and nursing homes than is necessary. A detailed audit of nursing home placements in England and Wales (Ref. 31) found that only 60 per cent of older people admitted had had an assessment by a consultant geriatrician or psycho-geriatrician recorded on their files prior to admission. Those from hospital were slightly more likely to have had such an assessment than those from home. Over 90 per cent of the records contained no physiotherapy or occupational therapy reports of pre-admission treatments, pre-admission assessments and post-admission management. If ‘the lack of documentation reflects a lack of formal therapy assessment, this would indicate a national failure of multidisciplinary assessment prior to the referral and placement of older people in nursing homes’. The audit concluded that between one in six and one in seven residents were ‘misplaced’.

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**CASE STUDY 8**

Sheffield standardised screening assessment

The standardised screening assessment has three components:

- A standardised disability assessment completed by staff on the ward.
- A questionnaire completed by the patient.
- A questionnaire completed by a carer, if relevant.

The ward-based assessment has a range of questions about the patient that cover mobility, continence, the ability to self-medicate, transfer, use toilets and bath or shower, and the ability to maintain personal hygiene, dress, feed themselves and speak. They trigger referrals to physiotherapists, occupational therapists, continence nurses, dieticians and speech and language therapists.

The questionnaire also reviews how well people were managing before admission, looking at their ability to maintain the home, cook, shop, handle money, use the telephone, self-medicate, move around indoors and outdoors, transfer, use the toilet and the bath or shower, manage continence, maintain personal hygiene, dress and feed themselves. It also asks about sight, hearing and mental state. It asks for information on who would give assistance if the patient did have any difficulty in these areas.

The carer questionnaire covers similar issues and enables the carer to express any worries or concerns about the patient’s ability to cope. The screening assessment helps to identify and document the patient’s needs for a wide range of help, to ensure appropriate referral and to plan adequate discharge arrangements.
73. Where different agencies carry out assessments, problems occur when each agency uses separate assessment tools leading to repetition and increased costs. Two sites visited during the study were in the process of developing community-based shared assessment protocols but they were very much in a minority. A review of documents used for the comprehensive assessment of older people in 50 local authorities across the UK (Ref. 32), found that very few documents were designed to pick up information on the potential for rehabilitation. Only 24 per cent of forms were used jointly by health and social services, leaving the majority of social services staff to seek specialist assessments from other agencies and professionals where necessary. The review reported a ‘marked variation not only in the content of assessment (the information sought about needs and how it is recorded) but also in the form (the personnel involved in conducting the assessment)’. Yet, a number of tools already exist that have been validated and that provide a set of questions that trigger the appropriate multidisciplinary input [BOX C, overleaf].
Some standardised assessment tools

EASY CARE ELDERLY ASSESSMENT SYSTEM – UK VERSION (1999–2002)
This has been developed by Professor Ian Philp at the University of Sheffield. It:

- is a standardised first stage assessment designed for use in primary care settings by community nurses and social care staff;
- is designed to be short, reliable and valid with potential for cross-cultural use;
- is used at initial contact with an older person; when there are changes to their health or social circumstances; as part of screening; to monitor outcomes of care and when assessing for placement;
- can be adapted through the addition of questions according to local need;
- requires appropriate casework to make the necessary referrals and follow-ups; and
- allows for the aggregation of client data for planning and audit purposes.

THE MINIMUM DATA SET (MDS)
Minimum data sets (MDS) have been developed by an international group of researchers and clinicians in elderly care. MDS are available for:
1. Acute hospital care
2. Rehabilitation/post-acute care
3. Home care
4. Residential home/nursing home

Each:

- covers a broad range of assessment domains;
- is designed so that specific responses to items ‘trigger’ reference to in-depth assessment protocols and prompt a wider assessment;
- allows for repeated assessment at intervals, allowing changes to be monitored over time to show the outcomes of interventions; and
- enables the aggregation of client data for planning and audit purposes.

ROYAL COLLEGE OF NURSING ASSESSMENT TOOL FOR NURSING OLDER PEOPLE
Developed by the Royal College of Nursing, this:

- is designed for use by nursing staff as part of the overall assessment of a resident in a care home but can be used in the community or in hospital settings;
- enables comprehensive assessment of an older person’s health status;
- enables the need for input by a registered nurse to be identified through the application of a stability/predictability matrix;
- allows an estimate to be made of the registered nursing hours required, through the use of a scoring formula;
- enables evidence to be identified that supports decision making and practice;
- contributes to the generation of a care plan; and
- can act as a trigger for further, more specific assessment.

Source: King’s Fund (Ref. 33)
Care planning

74. Good care planning should then follow assessment. Older people are central to the process, and yet, a large number of patients in the user survey, 42 per cent (n=161), were not even told what a stroke was while in hospital [EXHIBIT 24]. Communication between therapists and older people about their care is also sometimes poor. The user survey asked people how therapists asked them about the sort of help they needed (for example, walking, talking, making tea, sitting, dressing etc). Most (61 per cent) reported good or reasonable levels of communication but a considerable minority (27 per cent) reported poor or very poor communication [EXHIBIT 25, overleaf].

75. As rehabilitation is often an active, painful process, the lack of information about the nature of a stroke and consultation about overall goals is striking. Goals agreed with the patient are at the heart of the rehabilitation process. To be successful they should be:

- clear and unambiguous;
- meaningful – appropriate to the problems and circumstances of the patient;
- agreed – negotiated with patient, caregivers and rehabilitation team;
- clearly communicated and written down; and
- realistic – challenging but achievable: not everyone can do everything (Ref. 6).

EXHIBIT 24
Users’ views about an explanation of stroke

42 per cent of patients were not even told what a stroke was while in hospital.

Source: Audit Commission user survey

The central involvement of users in the process is well recognised in therapists’ own guidelines on clinical practice. OTs should at all times… acknowledge the need for client choice and the benefits of working in partnership (Ref. 34) and the ‘record of recommendations [following an assessment] shall [include] the consumer’s goals and/or the goals of his family or carers’ (Ref. 35). For physiotherapy, treatment ‘plans, goals and predicted outcomes are agreed between the patient and the physiotherapist’ (Ref. 36). Although the time pressures on therapists are well recognised, if they do not consult, therapy is not a patient-centred process but a professionally imposed one. In the stroke user survey, a higher proportion of patients treated on stroke units were told about stroke and experienced a significantly better dialogue with therapists.

EXHIBIT 25

Users’ views on communication with therapists in hospital

A considerable minority (27 per cent) reported poor or very poor communication.

Q4 When therapists came to see you in hospital, how often did they ask you what things (like walking, talking, making tea, sitting or dressing) you wanted to work hardest on?

Source: Audit Commission user survey
**Continuity of care**

**77.** Arrangements for transferring care plans with people when they move between services and organisations need to be clear and in place.

**78.** While all of the sites visited had rehabilitation beds, the location of these beds differed from site to site. Three sites had combined acute/rehabilitation beds, five had separate rehabilitation beds on the acute site, five had separate rehabilitation beds off site and two had rehabilitation beds both on the acute site and off site. Critically, for the organisation and management of care, this meant that rehabilitation often involved a transfer – either within a site, or between sites. Sometimes the transfer was between organisations. Despite the number of transfers needed, only one site had a transfer protocol, for one particular service [EXHIBIT 26].

**EXHIBIT 26**

**Protocols for the transfer of older people to rehabilitation beds**

Despite the need for a high number of transfers, only one site had a transfer protocol, for one particular service.

**Source:** Audit Commission study site data
79. For stroke patients, multidisciplinary teams were predominantly concerned with the management of inpatient rehabilitation. Only three teams provided any ongoing support in day settings or in people’s own homes. Yet only three of the other teams had explicit protocols for transferring care plans. This meant that in many cases, continuity of care relied at best on verbal discussions between services or other informal exchanges of information.

80. The user survey found that the shortfalls in the arrangements for ensuring continuity of care were felt by users themselves. Many require a range of help on discharge – social care, health care or equipment. Social and health care need good co-ordination, and equipment needs to be put in place in a timely way. The user survey found that 53 per cent (n = 203) said that they needed new equipment at home after their stroke care in hospital, but the majority reported that it was not available at home on discharge. Only just over one-fifth reported that on arrival back home all of the equipment was in place. Nearly one-half reported that none was. The delivery of equipment to users who had received their rehabilitation in a stroke unit was significantly better [EXHIBIT 27], suggesting that the better management and co-ordination in these services resulted in improved continuity of care.

EXHIBIT 27
Users’ views on the availability of equipment at home on discharge

The delivery of equipment to users who had received rehabilitation in a stroke unit was significantly better.

Source: Audit Commission user survey
Continuity of care depends on the availability of day and community-based services to complete rehabilitation, and to monitor and review progress. The lack of these services in many areas has already been described. Just under one-half (44 per cent) of users reported never going to outpatients or to a day hospital and well over one-half (59 per cent) never received therapy at home on discharge. For those who were able to access these services, over 70 per cent reported that access was soon enough after discharge, implying good continuity of care.

One approach that helps to achieve better continuity is the development of protocols. Another approach is to provide ongoing outreach services that link to earlier services. A third approach is to ‘inreach’. In Sheffield, the multidisciplinary community rehabilitation teams (CRTs) described in Case Study 5 recruited two community rehabilitation liaison nurses who ensure the timely, appropriate and effective assessment and transfer of patients requiring the services of the CRT. They achieve this by:

- providing ‘inreach’ into the hospital, assessing clients with the ward-based teams and then facilitating their transfer to the community;
- liaising with other community-based services and social services;
- ensuring accurate information is communicated between hospital and community staff;
- informing medical, nursing and therapy staff about the role and function of CRTs; and
- providing ongoing support to patients and their families being discharged to the CRTs, while in hospital, and when at home.

Finally, a fourth mechanism that can facilitate continuity of care is a ‘key worker’ system. Key worker systems are particularly useful in the management of patients in the community, where patients are located away from the team itself but where good communication and co-ordination is essential. The North Devon Re-ablement Team sees its key worker system as essential to the successful operation of the team [CASE STUDY 9, overleaf].
Organising and delivering care

Good organisation is essential if the effectiveness of rehabilitation is to be maximised. This requires above all good team work between professionals.

Team work

The process of rehabilitation has been described as ‘continuous and multifactorial... dependent on multiple inputs’ (Ref. 37). Rehabilitation requires ‘a range of competencies and expertise not available from any one member of the team’ (Ref. 38). Different professions, often from different organisations, need to work together. Effective team working is essential to good outcomes.

Team working, particularly in multidisciplinary teams, can be seen as a way of tackling the ‘potential fragmentation of care; a means to widen skills; an essential part of the complexity of modern care; and a way to improve quality for the patient’ (Ref. 39). However, while all teams are groups, not all groups are teams. Teams form, or are formed, to work towards a common purpose. Essential to this are clear objectives, interdependence, effective communication and clearly defined roles. This, in turn, requires effective leadership. Teams need to link into management structures. However, one of the greatest barriers to effective team working is the organisational context.
Effective team working and communication are difficult. Research has shown less than one in four health care teams are building effective communication and team working practices (Ref. 40).

Some have argued that team working costs more because of the additional costs of meeting together. However, not meeting together incurs costs through duplication of effort caused by multiple overlapping assessments and communication failures between specialties and sectors. Effective teams also save costs in other ways, such as shared files and notes. Unfortunately, many teams do not appear to be maximising their potential to co-ordinate care better.

All of the sites visited had an inpatient multidisciplinary team working with older people and with their rehabilitation, but only two teams used a single collaborative set of case notes and only one team prepared a single plan. In most cases, team members continued to use their own professional notes, often kept separately, and each member of the team prepared and worked to their own plan, although hopefully after discussing and sharing it with other members of the team.

There often appeared to be confusion about what constitutes a ‘team’. A recent survey of community rehabilitation teams had to exclude just under one-quarter of the returns because the community rehabilitation ‘team’ turned out to be an individual worker (Ref. 27). The same survey found particular problems with the management of such teams. Just under one in ten of teams ‘were unable to give a satisfactory and clear explanation of how their team was managed’. In one in ten teams, management was provided by a ‘distant absent manager’. In one-quarter, there was no ‘team’ manager – instead separate heads of services managed each member. In effect nearly one-half of teams were without ‘team’ management. Only just over one-quarter of teams had a clear arrangement, with a team manager to whom the whole team was accountable for clinical and non-clinical matters. The same survey reported that the majority of teams did not use any regular assessment or outcome measures to monitor and review what they did and what they achieved.

Many teams do not appear to be maximising their potential to co-ordinate care.
Nevertheless, there are examples of serious efforts to improve multidisciplinary working. The North Devon Re-ablement Service described in Case Studies 6 and 9 provides professional assessment followed by a rehabilitation programme in people’s own homes with goals agreed between the patient and the team. While the teams are based in hospital, allowing some inreach work, the vast majority of activity takes place in people’s own homes. Liaison with all other services (for example, district nursing) and the primary care team is very important [CASE STUDY 10]. In summary, the main features of the model of multidisciplinary team working are:

- comprehensive multidisciplinary membership;
- team management through a single team manager;
- regular case meetings (weekly) and team meetings (every six weeks);
- shared multidisciplinary case notes;
- a key worker allocated to each case to co-ordinate care;
- assessments carried out according to agreed protocols;
- goals agreed with the patient and/or carer – they receive a copy of the care plan;
- protocols developed for sharing information – free flow of information and good communication is essential to team working;
- review and discharge dates set according to protocol arrangements; and
- data collected to aid service evaluation.

Another example – this time of a team working together well in a hospital – is the Bradford Stroke Unit [CASE STUDY 11, overleaf]. Prior to the establishment of the unit, stroke patients in Bradford were scattered across many different wards. The establishment of the unit has allowed multidisciplinary working to develop much more fully. The overall length of stay has reduced to an average of 31 days. The unit has a policy of admitting patients of any age or circumstance if conscious, yet it still achieves a rate of return home of nearly 60 per cent.
North Devon Re-ablement Service – team work

- The service is multidisciplinary. Members include: manager, co-ordinator (admin/clerical), nurse, physiotherapist, OT, speech and language therapists (SaLT), support workers, medical sessions and social workers. There is also access to psychologist input.
- There is a team manager and team members report to the manager. The lines of accountability are clear. (They get professional support by keeping a reporting line to their professional heads). There is time for communication between team members. Flexibility is seen as essential. Support workers will do what is required through flexible working.
- The team meets weekly for allocation and review and every six weeks for a broader team planning meeting. Everyone attends including the doctor.
- At the point of referral, multidisciplinary case notes are created (and with greater social services input these are to become multi-agency too). The team operates a shared file system. Background information is collected only once. Colour coded sections are then completed by the relevant disciplines. There is also a team communication record (patients can complete this too). Patient-held records are maintained throughout.
- Appropriate referrals normally go to the weekly allocation meeting, but urgent referrals are responded to within two days. Each referral is allocated a key worker to co-ordinate their treatment plan.
- Core information is gathered using agreed assessment protocols. Carers are asked if they want an assessment of their own needs.
- Goals are agreed with the patient and/or carer. A re-ablement plan incorporating patient goals and care is agreed. Individuals receive copies of their care plan.
- The person making the initial face-to-face contact introduces the service and leaves information about the services and a communication record.
- After initial contact, a review date is set. At this, either another review date or a discharge is planned. Contact is maintained with relevant services throughout – for example, GP, primary health care team, SSD. Wherever possible, team members attend local primary care groups.
- Service performance evaluation is measured using baseline data on patient characteristics, referral source, length of stay and outcome. Client and carer satisfaction is monitored.
CASE STUDY 11

Bradford Stroke Unit

Prior to the establishment of the stroke unit, patients in Bradford were scattered across many wards at St Lukes and Bradford Royal Infirmary. An audit in 1995 showed stroke patients present on 15 wards. In October 1997, the stroke unit was established with 21 beds.

The policy is to admit patients of any age if conscious. Patients are identified by ‘liaison nurses’ who ‘case find’ and carry out pre-transfer assessments according to an agreed protocol. Once on the stroke unit, the multidisciplinary team provides care. Membership comprises: social services staff, SLTs, physiotherapists, nursing staff, therapy assistants, physicians, and stroke outreach staff. Generic therapy assistants provide support to all therapy disciplines. A specific training programme has been developed. The staff work under the close supervision of the lead therapist and usefully extend the therapy day to weekends.

Being a designated unit allows a clear patient focus with a common purpose. Other approaches aid team working, co-ordination and ensure continuity of care. These are:

- **smaller sub-teams** – three smaller teams, each focused on seven beds, provide a highly individualised rehabilitation focus to seven patients. This allows one-to-one psychological support that is a vital aspect of stroke recovery and adjustment;

- **goal planning** – each patient is reviewed weekly by the team to discuss progress and to plan multidisciplinary short- and medium-term rehabilitation goals with dates of expected achievement. The unit is experimenting with patients and carers attending the meeting to maximise their involvement;

- **full team meetings** – are held weekly and involve community and social services staff;

- **collaborative case notes** – these are used to support team working by sharing assessments, progress and information;

- **interdisciplinary training** – the unit developed an in-house interdisciplinary training programme that has been evaluated by an externally funded research project. This demonstrated that the programme achieved measurable improvements in care;

- **education** – a weekly multidisciplinary teaching session is held at which all staff on the unit take turns to present a pre-arranged stroke topic. External speakers are also invited;

- **audit** – the unit participates in the Royal College of Physicians national stroke audit and has also established an ongoing audit based on a validated patient satisfaction questionnaire sent to all patients after discharge;

- **patient information** – the unit has developed its own ‘easy guide’ to help patients and their families to better understand stroke. A stroke information pack is also provided around the time of discharge. A telephone helpline has been established for carers and ex-patients of the unit.

- the **overall length of stay** has shortened to an average of 31 days in the Stroke Unit and the overall time spent in hospital is 43 days. The unit takes all strokes but still achieves a return home rate of nearly 60 per cent. Around 30 per cent enter long-stay care (two-thirds of these enter nursing homes); and

- **continued care** – is available through a stroke-specific outreach physiotherapist who attends team meetings and through a neurology outpatient clinic.
Stroke care

93. There is strong evidence, according to the Stroke Unit Trialists’ Collaboration, that organised stroke care (provided by a multidisciplinary team in a stroke unit) reduces mortality and improves outcomes (lower institutionalisation rates) significantly (Ref. 20). There is sufficient evidence to support the setting up of well-organised stroke services. Care provided by a multidisciplinary team on a stroke unit achieves a better patient outcome than care provided on a general medical ward.

‘The evidence indicates that these services should provide comprehensive care centred on an integrated multidisciplinary team who have a specialist interest in stroke rehabilitation. A team is a group of individuals who share common values and work towards common goals. Such teams usually work in a geographically defined stroke unit. Sometimes teams care for stroke patients throughout a hospital without a defined unit. Features distinguishing such services from general medical services are: co-ordinated interdisciplinary care, involvement of family and carers in the rehabilitation process, specialisation, and education of staff, patients and carers’ (Ref. 20).

94. Despite the evidence, much stroke care and rehabilitation remains fragmented and disorganised. As far back as 1988, a conference at the King’s Fund Centre (Ref. 41) concluded that stroke services that are provided in hospital, primary care, and the community seemed haphazard, fragmented and poorly tailored to the patient’s needs. In 1998, the Clinical Standards Advisory Group also found that standards of service varied widely around the country, and that practice was often poor (Ref. 42). Out of 20 trusts, 13 had a designated stroke service, of which 9 could properly be called stroke units. A Stroke Association survey, published in 1999, found that only one-half of stroke patients received optimal specialist stroke services on a stroke unit or through a stroke team (Ref. 43). Finally, the National Sentinel Audit of Stroke, published in December 1999, found that less than one-half of all trusts participating had stroke units (Ref. 44). Only 18 per cent of patients spent more than one-half of their stay on stroke units, 15 per cent on rehabilitation units and 67 per cent on general medical wards. However, their findings confirmed that patients received better care within stroke units. They also specifically reported that care in stroke units was significantly better than that in general rehabilitation units as well as that on general medical wards. They found that many aspects of care did not meet basic standards.
Audit Commission findings are very much in line with these results: dedicated stroke beds (a stroke unit) were accessible to people aged 75 and over in only one-half of localities, and the number of beds available for rehabilitation varied nearly fivefold. Of the 16 study sites, 11 had a ‘lead’ consultant and a dedicated multidisciplinary team working on stroke rehabilitation, but none worked with all cases including ‘outliers’ placed elsewhere. In five, no multidisciplinary team was dedicated to stroke rehabilitation, despite the needs and proven benefits.

The management of ‘outliers’ is important. Although a stroke unit, or designated beds may exist, capacity is inevitably limited, and some patients receive their rehabilitation elsewhere. Such patients do not receive the full benefits of care provided by the trained multidisciplinary team working with stroke patients. In 6 hospitals studied in detail, widely varying proportions of patients aged 75 and over with a stroke were still on acute wards 21 days after admission [EXHIBIT 28]. Significant proportions of stroke patients in all six hospitals never gained access to either a stroke unit or a rehabilitation ward [EXHIBIT 29].

EXHIBIT 28
Percentage of stroke patients aged 75 and over on acute wards 21 days after admission
A large proportion of patients are still located on the acute wards in some locations.

Source: Audit Commission stroke case analysis
EXHIBIT 29

Patient locations – completed stays

In some locations, a majority of patients aged 75 and over do not gain access to a stroke unit or rehabilitation ward.

Source: Audit Commission stroke case analysis

Conclusion

97. Taken together, the picture is one of disorganised rather than organised care. Certainly, the management and organisation of care is much less than is needed to reap the full potential benefits. The authors of the National Sentinel Audit for Stroke note that collecting stroke ‘patients together in a stroke unit should lead to improved efficiency, rather than greater costs’. Also, at ward level, the development of protocols for managing common stroke complications, improving communication through regular meetings and sharing notes, and involving patients and carers in the planning of care are all achievable without much financial investment. The clinical and cost evidence is such that no one should be denied access to organised stroke care, and the benefits of multidisciplinary assessment and rehabilitation should be available to all older people who could benefit.
Managing the Rehabilitation Programme

Rehabilitation programmes need to be better managed:

1. Agencies ought to be considering their screening arrangements and developing assessment procedures together that review people’s potential for rehabilitation.

2. Good communication is essential for success: people need to become fully and positively engaged in their own rehabilitation programmes, which can often be difficult and painful.

3. Extra care is needed when people transfer between services and organisations.

4. Good team working is important, with multidisciplinary and multi-agency teams working to a single manager and with protocols setting out what is required when people are moved on to receive other services.

5. Organised stroke care should be available to all who could benefit.
Therapists and Rehabilitation Services

Therapists are key members of any multidisciplinary rehabilitation team. More are needed, requiring better long-term workforce planning. In the short term, the level of therapy can be increased by using therapy assistants and using qualified therapists more flexibly.
Therapists play a crucial role in the delivery of rehabilitation services. They are important members of teams and are central to assessment, the setting of goals and the provision of care and services. Recently, they have been coming under increasing pressure. The numbers of initial contacts (new referrals) have been increasing steadily over the last ten years [EXHIBIT 30]. If authorities and trusts are to deliver rehabilitation programmes successfully, they must manage this key resource with care, and that is the subject of this chapter. Therapists do more than rehabilitation. While this report focuses on their contribution to rehabilitation, this chapter touches upon issues of wider relevance.

Despite the growth in the numbers of therapists, there remain genuine difficulties in meeting demand in many areas. If scarce therapy time is to be used to best effect, it must be matched to demand carefully. Measuring demand is therefore the first step in an effective management programme. An accurate picture of demand requires information about how many people are referred, how many times they are seen, and who sees them, which in turn depends on the complexity of their needs, or ‘casemix’.

Physiotherapy and occupational therapy departments make annual ‘Korner’ returns to the DoH, that record how many people are seen (the total number of initial contacts) by age and source of referral. For occupational therapy, additional information is collected on how many times people are seen and where they are seen. Apart from ‘Korner’ data, departments collect other information about demand, but to very varying degrees. Two sites were using ‘physiotherapy input units’ (PIUs) that are

**EXHIBIT 30**

**Therapist initial contacts as a percentage of 1988/89 level**

Initial contacts with therapists have increased considerably over the last ten years.

![Graph showing initial contacts as a percentage of 1988/89 level](image)

Source: DoH data
simple input measures that take casemix into account [BOX D]. Stockport Hospital NHS Trust physiotherapy department was using PIUs and the department manager found them useful in monitoring and moving staff between specialties to areas of greatest need [CASE STUDY 12].

**BOX D**

**Physiotherapy input units (PIUs)**

<table>
<thead>
<tr>
<th>Weighted contacts:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>x 0.63</td>
</tr>
<tr>
<td>Assistant</td>
<td>x 0.35</td>
</tr>
<tr>
<td>Staff grade/basic grade</td>
<td>x 0.63</td>
</tr>
<tr>
<td>Senior II:</td>
<td>x 0.8</td>
</tr>
<tr>
<td>Senior I:</td>
<td>x 1</td>
</tr>
<tr>
<td>Superintendent:</td>
<td>x 1</td>
</tr>
</tbody>
</table>

PIUs are a useful and simple way of measuring comparative demand on departments. For each patient, total contacts are recorded, along with the grade of staff carrying out the contacts. Each contact is weighted, according to the staff grade involved in therapy.

When aggregated over a service, the total (contacts x weighting) is a measure of demand that goes beyond the crude ‘contact’. It reflects the complexity of the cases handled, by assuming that more complex patients will require higher grade staff time. Patients in services can be ‘banded’ according to how many PIUs they have received. As such, PIUs are helpful for monitoring and contracting purposes: year-on-year comparisons can be made for a service. Also, weightings are based loosely on salary differentials, and can reflect the approximate cost of episodes of care.

However, the system assumes that the person carrying out the contact is the most appropriate person to do so, when in fact this may be more dependent on who is available. It also assumes that each patient has a sufficient number of contacts, when this too may also be affected by staff availability.

Modified PIUs can also be used in occupational therapy.

**CASE STUDY 12**

Stockport Hospitals NHS Trust physiotherapy department – use of therapy input units to link casemix and staff time

Stockport Hospitals NHS Trust physiotherapy department uses PIUs to monitor the input given to patients at ward level.

PIUs are used to record the physiotherapy inputs that can be related directly to named patients, including patient-related administration and direct contact time. A PIU is equivalent to ten minutes of helper time; other grades use a multiple of this unit to reflect their skill level, based on salary ratios.

Patients are allocated retrospectively into one of seven bands given different case weightings, depending on how many PIUs they receive. This information is aggregated at a ward and a specialty level, to monitor trends in the severity of cases passing through the ward or specialty.

The department manager has also used PIUs to calculate the cost of contacts with GPs.
The system for agreeing service levels for therapy does not encourage better demand information. Therapy is usually part of a block contract and normally service levels are set around ‘initial contacts per year’. Therapy services are listed as an ‘overhead’ on NHS trust financial returns. Therapy staffing levels have largely been set on an historical basis, based upon previous levels. Only two sites visited had attempted to set staffing levels in relation to any assessment of workload. In both these cases, the link between staffing and workload had been made for small, specific services rather than the whole department. In this context of poor information, poor commissioning, and staffing levels rolled forward each year, it is not surprising that the availability of therapists varies widely from locality to locality. For physiotherapy, data on the level of staffing in different localities show that the area with the highest staffing has 8 times more therapist time available per 100,000 population than the lowest. For occupational therapy the difference was sevenfold, while for speech and language therapy the difference was twentyfold. This variation shows the different priority accorded to the funding of therapy posts in different parts of the country, probably because of a lack of appreciation of the contribution they make to care.

Another problem is that national shortages make it difficult for some areas to improve the situation. Nationally, there are difficulties with recruiting and retaining staff, particularly ‘hands-on’ qualified staff. For physiotherapists, data from 48 trusts show that the staff in post as a percentage of established posts was lowest for the qualified grades (senior 1 and 2), and was highest for managers and assistants [EXHIBIT 31]. For speech and language therapists, the pattern was similar, with staff in post as a percentage of established posts lowest for the qualified grades, and highest for managers and assistants [EXHIBIT 32, overleaf]. The pattern was different for occupational therapy. Manager posts were furthest from establishment, but there were also significant deficits in qualified posts, especially senior 2s [EXHIBIT 33, overleaf].

These figures show the average staffing against establishment levels across 48 NHS trusts. The range between trusts is wide. For example, physiotherapy staff in post as a percentage of established staff for senior 2 grade posts is only just over 30 per cent in the worst case [EXHIBIT 34, overleaf], and only 8 trusts are staffed at or above establishment levels. For occupational therapy, the staff in post as a percentage of established staff for senior grade 2 posts is under 20 per cent in the worst case but over 50 per cent of trusts are staffed at or above establishment [EXHIBIT 35, overleaf]. Trusts occasionally recruit above establishment levels, on the rare occasions where more than enough suitable candidates apply for posts, grabbing qualified staff when they can get them.

Staff shortages affect patients. The user survey found that while over one-half of stroke patients were satisfied with the amount of therapy they received, nearly one-third felt that contact was ‘not often enough’ [EXHIBIT 36, overleaf].
EXHIBIT 31
Physiotherapy staff in post as a percentage of established posts
This is lowest for the qualified grades (senior 1 and 2) and is highest for managers and assistants.

Source: Audit Commission locality data collection

EXHIBIT 32
Speech and language therapy staff in post as a percentage of established posts
This is lowest for the qualified grades, and highest for managers and assistants.

Source: Audit Commission locality data collection
EXHIBIT 33
Occupational therapy staff in post as a percentage of established posts
Manager posts are furthest from establishment, but there are also significant deficits in qualified posts, especially senior 2s.

Source: Audit Commission locality data collection

EXHIBIT 34
Physiotherapy staffing in post compared to establishment – senior 2 grade
This is only just over 30 per cent in the worst case, and only 8 trusts are staffed at or above establishment levels.

Source: Audit Commission locality data collection
EXHIBIT 35
Occupational therapy staffing in post compared to establishment – senior 2 grade
This is under 20 per cent in the worst case, but over 50 per cent of trusts are staffed at or above establishment levels.

EXHIBIT 36
Users’ views on contact with therapists in hospital after a stroke
Over one-half of users felt that therapy contact was ‘about right’, but nearly one-third felt that contact was ‘not often enough’.

Source: Audit Commission locality data collection

Source: Audit Commission user survey
Professional locums and bank and overtime staff can be used to help offset shortages, at a cost. Spend on these as a percentage of total spend on therapy services for the 48 trusts is running at around 5 per cent for occupational therapy and physiotherapy and 2 per cent for speech and language therapy. However, these are averages and the full range of spend across trusts is wide [EXHIBIT 37]. For physiotherapy the range is from over 18 per cent to nil, for occupational therapy it is from 40 per cent to nil and for speech and language therapy it is from 11 per cent to nil.

Some of the wider issues are beyond the direct control of therapists themselves. They require action at other levels – by commissioners, by managers of trusts and by central government. In particular, if independence is to be promoted fully, workforce planning to make good the shortfalls will need to begin urgently. The extent to which a culture of independence can be achieved is likely to be seriously impeded by the lack of appropriately trained staff. Planning and co-ordination must start straight away. These issues are being addressed by two other Audit Commission reviews, both to be published in 2001 – one on non-medical education and training and another on the use of locums for nursing and professions allied to medicine.

However prompt the action, it will take time to increase the pool of professional staff significantly. Fortunately, local managers and therapists can take more immediate action to help to alleviate the difficulties. The collection of better information linked to more specific service agreements would be a good first step. Steps can also be taken to help to maximise the use of existing therapists’ skills and to improve their flexibility, as described in the following sections.
EXHIBIT 37
Spend on locums, bank staff and overtime as a percentage of total spend at NHS trusts on physiotherapy, occupational and speech and language therapy services

The full range of spend across trusts is wide.

Source: Audit Commission locality data collection
The level of rehabilitation provided for patients can be increased despite the general constraints on staffing. The availability of sufficient therapy is important. A randomised study of the intensity of leg and arm training after primary middle-cerebral-artery stroke (Ref. 46) found that an additional 30 minutes of therapy daily for 5 days a week for up to 20 weeks made a substantial difference to functional recovery. The benefit was achieved with a total of 1 hour and 20 minutes of rehabilitation therapy daily. A commentator in the *Lancet* noted that the research highlighted the benefits of therapy to patients after stroke and that ‘this study shows how great an effect a small quantity of a specific input may achieve… Few pharmaceutical or surgical interventions are so powerful’. (Ref. 47).

Therapy departments need to consider ways in which they can increase the use of non-professional clinical staff (assistants) and ensure that administrative and clerical support is sufficient to avoid high levels of clinical time being deployed on such tasks. Non-professionally qualified assistants and helpers are an important resource that can be used, with appropriate training and supervision, to help departments and professionals to meet rehabilitation goals. Assistants can be trained to carry out routine tasks or practice sessions with patients. They can increase the overall input to a patient on top of the amount delivered by qualified staff, and free up qualified staff to deal with other patients. This requires clear job descriptions, adequate supervision, and ideally, written protocols to guide assistant contributions. Assistants do not replace professional time, but help them to maximise their time.

There are no guidelines on recommended skill mix. Nationally, social services departments have increased the employment of assistants considerably (in whole-time equivalents) since 1995. In the NHS the number of assistants has failed to match the increase in professional staff. In NHS trusts, the use of physiotherapy assistants has increased very slightly, while the number of OT assistants and technical instructors has actually declined [EXHIBIT 38]. The ratio of physiotherapy assistants to qualified physiotherapists varies widely between hospitals [EXHIBIT 39, overleaf] and day services [EXHIBIT 40, overleaf]. The ratio of occupational therapy assistants to qualified occupational therapists varies widely between home-based services [EXHIBIT 41, overleaf].
EXHIBIT 38

Employment of assistant staff

Social services departments have significantly increased the whole-time equivalent employment of assistants since 1995 while in NHS trusts, physiotherapy assistants have increased slightly and OT assistants have declined.

Source: DoH data – SSD S001 return for social services data and non-medical workforce census for trust data
EXHIBIT 39
Assistants per qualified physiotherapist in bed-based rehabilitation services

The ratio of physiotherapy assistants to qualified physiotherapists varies widely between hospitals...

Source: Audit Commission locality data collection

EXHIBIT 40
Assistants per qualified physiotherapist in day hospitals

... and between day services.

Source: Audit Commission locality data collection
EXHIBIT 41
Assistants per qualified occupational therapist in home-based rehabilitation services
The ratio of OT assistants to qualified occupational therapists varies widely.

Source: Audit Commission locality data collection

...greater use of assistants...can help to improve services and outcomes.

111. Services that are experimenting with a greater use of assistants and helpers are finding that they can help to improve services and outcomes. At St Richards Hospital, Chichester, staff were concerned that rehabilitation inputs were not high enough. A team that included both professionally qualified staff and assistants increased treatment sessions for a group of patients, reducing length of stay and the need for transfers to other rehabilitation services, and increasing the rate of return home [CASE STUDY 13, overleaf].
The deployment of ‘generic’ assistants… helps by providing a much more flexible and efficient workforce…

CASE STUDY 13

St Richards Hospital Chichester – enhanced physiotherapy sessions for stroke unit patients

The Physiotherapist Team in Neurology comprises one senior 1, one senior 2, one junior and two part-time assistants. The team assesses and treats neurological patients on the stroke unit, the unit for young people with a disability, the admissions unit, medical and surgical wards and the private suite. They also have an outpatients list.

There was concern that patients were not receiving any more physiotherapy on the specialist units than on outlying wards. A project was started to treat patients twice a day on the stroke unit (instead of once) and to monitor length of stay and discharge destination.

Patients on the stroke unit after 1 May 1998 were treated twice daily (Group B), and were compared with those admitted earlier (Group A). Eligibility criteria for treatment remained unchanged. An audit showed patients in group B had a significantly reduced length of stay, a lower transfer rate for ongoing rehabilitation and a higher ‘return home’ rate.

<table>
<thead>
<tr>
<th></th>
<th>GROUP A admitted before the project</th>
<th>GROUP B admitted during the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Percentage discharged home</td>
<td>36</td>
<td>62</td>
</tr>
<tr>
<td>Percentage discharged to rehabilitation hospital</td>
<td>30</td>
<td>8</td>
</tr>
</tbody>
</table>

112. The deployment of ‘generic’ assistants, who cover more than one discipline, helps by providing a much more flexible and efficient workforce that fits well with the multidisciplinary focus of rehabilitation and the complex needs of patients and users. In Bradford, improvements to the rehabilitation of people who have had an amputation were achieved through improved multidisciplinary working and by increasing the amount of active rehabilitation through the introduction of generic therapy assistants [CASE STUDY 14]. The initiative has significantly increased the amount of time patients spend in therapeutic activity, reduced the length of stay, and returned patients to independent living. The Trust has concluded that there is good evidence that the approach has been effective and they are testing the transferability of the therapy assistant concept to other areas.
CASE STUDY 14

Bradford – improvements in amputation rehabilitation

This was an interdisciplinary project to improve the rehabilitation of patients requiring lower limb amputation. There was concern that inpatient stays were long and that patients had limited access to therapy activities, inhibiting the restoration of function. Although focused initially on a specific group of patients, it was hoped that the model, if successful, could be transferable to other areas within the Trust.

Recognising the benefits that could accrue from better multidisciplinary working in terms of improved functional outcomes through improved communication and support, the project aimed to:

- develop effective interdisciplinary working by improving communication across the team;
- improve the quality of care for patients by increasing the amount of active rehabilitation and creating an environment to maximise patient activity and independence;
- evaluate the impact of the generic therapy assistant role in increasing therapeutic activity;
- improve patient information; and
- reduce the overall length of stay and improve the discharge processes.

Organisational changes were introduced in order to try and achieve these aims. These changes included:

- a six bedded bay allocated primarily for patients requiring amputee rehabilitation;
- improved multidisciplinary team arrangements. Weekly meetings were introduced to discuss and review patient goals. A social worker was designated for this group of patients, helping to highlight and address factors affecting discharge. Daily team updates were introduced focusing on the care plans that had been developed;
- generic therapy assistants were introduced, employed on a seven-day week basis to increase the therapeutic activity undertaken by patients. They received competency based training in physiotherapy, occupational therapy and nursing skills relating to amputees;
- therapy assistants were focused on reducing solitary behaviour, increasing camaraderie, motivation, independence and a patient’s belief in his/her ability to recover. The bay was equipped with rehabilitation equipment and drink-making facilities to encourage early independence; and
- an information pack was introduced for patients.

Evaluation showed that a number of significant benefits and improvements flowed from these changes:

Demographic data relating to patients treated during the retrospective year prior to the project were similar in terms of the average age and sex distribution to the group treated under the new arrangements. Average age was 71.45 years for the retrospective group and 71.31 years for the prospective group. But, average length of stay was reduced by 32 per cent, from 43.39 days to 25.48 days. All patients returned to independent living. Observation of a random population of patients showed that the prospective group was spending 39 per cent as opposed to 5 per cent of observational periods for the retrospective group in useful therapeutic activity. The time spent in interactive behaviour doubled.

The Trust concluded that greater resources for a fuller evaluation would be welcome as the information collected suggested that a low-cost approach to changes in the organisation and delivery of rehabilitation is effective. Projects have been introduced to test the transferability of the therapy assistant concept to other specialties, including orthopaedics and stroke.
Improving flexibility

Greater flexibility and a more innovative approach could help therapists to improve their contribution to rehabilitation services. They could also play a significant part in helping to address issues to do with demand management across both health and social care.

Within acute services, too often the role of the OT is limited to ‘discharge facilitation’ or ‘safe discharge’. A more flexible use of therapists by trusts can help to reduce hospital admissions for those who genuinely do not require them. At the Princess Royal Hospital, Haywards Heath, the deployment of an OT within an accident and emergency unit helped to manage admissions to hospital of older people, and improved the quality of care given by providing advice, liaison, the provision of equipment and follow-up at home [CASE STUDY 15].

CASE STUDY 15

The Princess Royal Hospital, Haywards Heath, West Sussex – occupational therapy within A&E

An OT was placed in the accident and emergency department and medical assessment unit for a trial six week period. The aim was to provide objective information on the functional abilities of a patient to assist in deciding whether the patient needed to be admitted to a hospital ward or discharged.

Nearly 92 per cent of referrals came from A&E and just over 83 per cent of these were patients who had fallen, with or without fracture(s). Following OT assessment, under 30 per cent were admitted. Just under 80 per cent were aged 75 or over.

The OT interventions included:
- functional assessments – particularly of transfers and mobility;
- advice – for example, dressing techniques and the availability of community services;
- liaison with patient/family/carers for background information;
- liaison with and referrals to district nurses and social services for overnight visits, home care and the provision of equipment;
- the provision of equipment for discharge; and
- home visits following discharge on the same day or following day – to provide further advice/equipment/support to maintain safety and independence.

The average time spent with patients admitted was 1.75 hours and for patients discharged it was 3.5 hours.

Data for the six week period prior to the pilot were compared with data for the pilot itself (table below). When looking specifically at people aged 75 years or over, the percentage of elderly patients admitted to wards following assessment and treatment in A&E reduced by 10 per cent during the project period.

<table>
<thead>
<tr>
<th>A&amp;E admissions age 75 or over</th>
<th>Six weeks before pilot</th>
<th>Six weeks pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E admissions</td>
<td>274</td>
<td>308</td>
</tr>
<tr>
<td>A&amp;E onto hospital ward</td>
<td>105 (36.7 per cent)</td>
<td>85 (27.6 per cent)</td>
</tr>
</tbody>
</table>
In Victoria in London, a joint health and social care project has been set up to increase the levels of community-based occupational therapy to people aged 65 or over [CASE STUDY 16]. The project arose from concerns that, too often, patients left hospital without any plan for follow-up support in the community, resulting in some having to be re-admitted. Through focused assessment and care management, care costs have been minimised by promoting independence and not encouraging dependence. Savings have also been made in the provision of equipment through more effective assessment, practical problem-solving and good follow up. The project team also identified that increased use of assistants, provided there was commitment to appropriate training, could increase savings and ensure that qualified therapists were correctly used.

CASE STUDY 16

Victoria Project, London – enhanced community occupational therapy (Ref. 48)

The ‘Victoria Project’ (run by Riverside Community Health Care) was funded with a £50,000 grant by the King’s Fund to the Kensington, Chelsea and Westminster Commissioning Agency and Westminster Social Services. It was set up to explore how services could be purchased more effectively to meet the needs of elderly people in the Victoria district of London. The project provided a community assessment and rehabilitation service for people aged 65 and over. Service elements included:

- the assessment of functional ability;
- the rehabilitation to improve or maintain functional ability for up to three months;
- the provision of aids and minor adaptations to maximise independence within the home;
- the reduction of inappropriate or unnecessary dependency on services and carers;
- the introduction of a care management role, to ensure effective communication and referral onto appropriate agencies; and
- the provision of advisory and liaison service for other people working with the client group.

The team was also asked to evaluate the effectiveness of occupational therapy intervention and to provide a ‘blueprint’ for future patterns of care.

The evaluated impact of the project has shown that:

- there has been a substantial reduction in domiciliary care with subsequent savings to social services of over £65,000 per annum; and
- further savings on reduced equipment provision of £14,250 per annum.
Within social services, the role of the OT may be limited to the assessment for, and provision of, equipment and adaptations to people’s homes. This role fails to make full use of their skills. They can make a significant contribution to the assessment of older people at risk of entering long-term care, or in receipt of high-cost packages of care. Nottingham Social Services Department has begun to deploy its OTs in a much more creative way [CASE STUDY 17]. They are helping to manage down the level of home-care packages and the number of long-term placements in residential and nursing homes.

Taken together, evidence shows that a more flexible deployment of therapists, particularly OTs as part of a multidisciplinary approach, can make a significant contribution to help manage demand across health and social care, and improve outcomes and the quality of life of older people.

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**CASE STUDY 17**

**Nottingham – The strategic use of occupational therapy**

Nottingham City Social Services Department has reviewed the impact of occupational therapy skills within the framework of assessment and care management and home-care teams. The review uncovered potential savings to SSDs through more creative use of scarce occupational therapy resources.

The project began with an OT assessing the dependency levels of service users who were receiving home care five to seven days a week. Using a standardised dependency index, of those assessed (n =56) just over one-half were found to have the potential to be more independent. The review found that:

- some people discharged from hospital still had intensive packages many months later, suggesting the need for structured reviews; and
- home-care staff were performing tasks for people that they could do themselves, wasting resources and prolonging dependency.

This led to the OT reviewing selected home-care packages where there had been requests for more support. Out of 46 reviews, only 1 received an increase in service, with 10 having a reduced service and 6 having the service withdrawn.

During the same period, 21 people were referred for long-term placement in residential/nursing home care. Joint visits were made with social work staff and an OT assessment was completed. As a result, 12 people were kept in their own home, 8 of whom received OT support.

The review of the project concluded that a more creative use of community OTs by social services can lead to more effective and cost-efficient community care services and can help to ensure that expensive home-care packages and long-term care placements are only used for people who really need them.
Therapists and Rehabilitation Services

Therapists need to play their full part:

1. Workforce planning is needed by central government to provide enough staff.
2. Within services, good information is needed on where the pressures are occurring.
3. Local managers and therapists need to maximise the use of skills by using assistants and helpers, and by deploying qualified therapists more flexibly.
Developing A Strategic Approach

A strategic approach is needed that involves a shared understanding of what is required and a whole systems approach that looks at rehabilitation in the round, and makes full use of new financial flexibilities.
A strategic approach is essential to the development of rehabilitation services, because of the nature of the services and processes of care, involving many different authorities, trusts and professions in different settings. If services are to improve, commissioners and providers of services need to address the deficits set out in this report together. The key questions posed in this report are:

- Is it clear what role each service plays within the local framework of rehabilitation services, and are there any gaps? In particular, is there access to multidisciplinary assessment, rehabilitation and review in the community?
- Are care pathways well managed, with mechanisms in place for screening and assessment, care planning and good continuity as patients and users move between services and agencies?
- Are therapists, as a key resource in delivering rehabilitation services to older people, managed so as to maximise the use of their skills and to promote flexible patient-centred care?

If this agenda is to be implemented across health and social care, the changes required in many areas to services, practice and culture will be significant. They will require careful review, planning and implementation. They will need to be based on the best evidence available, and be carefully monitored. All of this will require a strategic approach, involving:

- a shared understanding of what is needed;
- a whole-systems approach; and
- use of the new financial flexibilities.

Health authorities and trusts, primary care groups and trusts, and local authorities will need to share a common view of what needs to be done. The need for better joint planning between health and social services has long been recognised. However, what is less well recognised is that many of the difficulties occur because of discontinuities between different parts of the NHS. The barriers between acute and community health services, and between acute and primary care services, can be every bit as high as those between health and social care. In the past, the main focus of much NHS care has been on treating specific conditions, rather than on managing care. The Secretary of State for Health has commented that:

(NHS) care has traditionally been about dealing with life's incidents – heart attacks and broken bones. Now an ageing population and increasing chronic disease means NHS care has also to be about dealing with life's experiences – getting older and becoming frailer. In other words, proactive and ongoing care not just reactive and episodic care

(Ref. 49).
The NHS needs to be less short term if care is to be ‘proactive and ongoing’, while local authority social services will need to be more short term if they are to promote independence. This changing agenda will require some major changes in approach by many involved with the care of older people. Two examples are given below to illustrate this point: physicians specialising in the care of older people (geriatricians); and social services.

122. The role of geriatric medicine is critical to the improvement of these services with its emphasis on holistic, multidisciplinary care focused on aspects of ‘reversibility’. The specialty of geriatric medicine arose to promote progressive patient care for older people. Initially, practitioners, working in isolated long-stay hospitals focused on long-term assessment and rehabilitation and were often cut off from access to the expertise and resources of the acute hospital. Increased integration with general medicine in the 1980s and 1990s has meant that isolation is much less of a problem. However, isolation has been overcome ‘at a price. This price has become increasingly apparent with the strains caused by the apparently inexorable rise in the numbers of patients seen on the acute take [EXHIBIT 42], and the loss of rehabilitation resources and input into long-term care’ (Ref. 50). This pressure in acute care is a major focus of geriatric medicine today. Both trends described – the loss of services and the reduction of time spent in the community and on long-term care – need to be addressed in a way that will also retain the benefits of integration as well.

123. The role of local authority social services departments in promoting independence is essential. The white paper Modernising Social Services (Ref. 15), set out the Government’s view that social services departments need to move away from a culture of providing services that ‘do things for and to dependent people’. The aim of rehabilitation services is to help people to get better, improving their health and social functioning, rather than reinforcing their dependency. To help to develop better rehabilitation services for older people, social services could:

- develop or contribute to services especially in intermediate and community settings;
- contribute to effective multidisciplinary screening and assessment arrangements;
- manage community occupational therapy assessments and deliver help in a way that contributes towards good continuity of care;
- make better use of the therapeutic skills of the OTs they employ; and
- contribute to effective partnership working and strategic planning, through their relationships with health authorities and trusts, primary care groups and the independent sector.
There has been an inexorable rise in the numbers of patients seen on the acute take.

Significant amounts of money for modernisation have been made available by government to improve services. Between 1999 and 2002, £747 million is being channelled through local government, through partnership, prevention and carers’ grants to promote independence. If this money is to be used to best effect, a shared dialogue is needed with genuine joint planning involving all of the players.

A framework is needed to help promote a shared understanding. In England, the initiative set out in Better Services for Vulnerable People (Ref. 8) requires joint investment plans (JIPs) with details of the resources of both agencies, service provision and gaps, and planned improvements. The JIP, in turn, contributes to the Health Improvement Programme. In Wales, there has been a strong emphasis on the need for effective joint working to produce Health Improvement Programmes. Such joint working has been greatly helped by common boundaries for local health groups (LHGs) and local authorities.
A whole-systems approach

As well as a shared understanding, a whole-systems approach is required if these services are to improve. Such an approach is not just about bringing all the key players together: it involves careful, systematic and detailed mapping of the services, pathways and processes within health, and across health and social care. It then requires systematic planning of any changes needed to bring improved care across all of those services. Finally, it means managing those changes into being, and monitoring and evaluating the outcomes.

Such an approach has been adopted in North West Surrey in their work to modernise services for older people. The aim has been to reconfigure services for older people with improved assessment arrangements at all levels, clear aims and purposes for each service, and greater flexibility and improved efficiency of the care process. Centred around the development of a multidisciplinary Rapid Response Integrated Care Service (RRICS), significant change and improvement is being achieved. Emergency admissions are being reduced and average lengths of stay are declining in both acute and community hospitals. Implementation is focusing on improving key elements of care – screening, assessment, information flows and exchange, and flexibility of response and review [CASE STUDY 18].

The approach in North West Surrey shows what can be achieved by a whole-systems approach to services. A fundamental review of all service provision and processes of care is essential. It is the absence of systematic processes of care that is notable in relation to these services for older people, for:

- identifying and meeting rehabilitation needs through screening and appropriate assessment;
- managing and organising care, particularly stroke care, in line with best evidence;
- ensuring continuity of care; and
- promoting ongoing monitoring and review.

The National Service Framework for Older People needs to ensure that these issues are covered, and standards developed, to improve care processes and the experience of patients through their pathway of care.

The National Priorities Guidance for health and social services requires health and local authorities to work together with a range of partners to ‘carry out a multidisciplinary audit of existing services for older people in preparation to implement the National Service Framework for Older People’ (Ref. 52). A programme of local audits of rehabilitation services for older people is being undertaken by the Audit Commission to assist in this process. For the first time, auditors are being appointed specifically to look at progress with these issues across agencies.
CASE STUDY 18

Modernising the care of older people within North West Surrey through a ‘whole-systems’ approach

Major changes have already taken place or are planned in the way in which older people with complex needs (generally those aged 75 and over) are cared for in North West Surrey. Local health and social care professionals agree that many older people are admitted to hospital, after having been allowed to get into crisis unnecessarily, and that others remain in hospital for longer than is necessary. A major re-engineering of services has occurred, closing acute beds and shifting investment into community-based assessment, treatment and rehabilitation. The aims of the reconfiguration are:

- improved efficiency of care processes – ensuring that people move through the system in a well co-ordinated way as their needs change.

Investment resources for change were only available through reductions in existing expenditure on acute hospital services and from ‘modernisation funds’. In 1999/2000 part year savings of £347,000 were released from the closure of a 30-bed ward which were re-invested in the new model of care delivery. Additional funds of just under £62,000 were also found. These resources were used to establish the Rapid Response Integrated Care Service. The aim has been to relieve pressure by providing flexible options to GPs to avoid admission, early direct discharge from A&E and more focused care in both the acute and community hospitals.

Detailed plans for change cover four main areas:

- **Scheme 1.** To divert an increasing number of people before they are admitted. This is achieved by providing an increase in the number and range of packages provided by the Home from Hospital Team and an increase in the medical advice available to GPs.

- **Scheme 2.** To reduce the length of stay of those who have to be admitted to hospital, by improving the management of care by community staff for those who can be discharged quickly, streamlining intensive integrated assessment arrangements and discharging those eligible for care in the community hospital faster.

- **Scheme 3.** To improve throughput (by 25–30 per cent) and reduce the average length of stay (from 39 to 28 days) in community hospitals.

- **Scheme 4.** To improve links between health and social services.

Taken together, these schemes streamline arrangements and improve the speed of response. The enhancement of the existing Home from Hospital schemes are essential to this. The teams lacked medical input so enhanced services were introduced in 1999/2000. Henceforth, they will provide a more rapid response and will include consultant medical as well as additional therapy input. Enhancements will ensure that patients receive an expert assessment from a specialist team to provide:

- consultant domiciliary visits when diagnosis is unclear;
- urgent outpatient appointments;
- home care for people who would otherwise be admitted;
- speedier multidisciplinary assessment in A&E for those who need it;

The agencies involved are the Bournewood and Hounslow and Spelthorne Community NHS Trust; Ashford/St Peters (acute) NHS Trust; Surrey Social Services Department; West Surrey Health Authority; Elmbridge, Surrey Thames and Woking Primary Care Groups and Surrey Ambulance Service.

continued overleaf
Modernising the care of older people within North West Surrey through a ‘whole systems’ approach

- speedier multidisciplinary assessment in A&E for those who need it;
- regular reviews of all hospital inpatients over the age of 75 to secure earlier discharge;
- improved co-ordination of discharge;
- co-ordinated and speedier transfer to community hospitals; and
- improved liaison with social services and families.

To date the achievements have included:

**Scheme 1.** The number of A&E attendances has continued to rise by 5.8 per cent in the last year (comparing the first nine months of 1999 with the same period in 1998). However, over the same period, in St Peter’s Hospital in North West Surrey served by RRICS, admissions have reduced by 367, saving 5,138 bed days overall (assuming an average length of stay of 14 days).

**Scheme 2.** Significant reductions in the length of stay for those who are admitted is being achieved, and nearly all of the reduction is accounted for by a drop in the length of stay for older people. Overall, the average length of stay (ALoS) for all adult and elderly admissions has fallen from 9.2 days to 8.5 days. For those aged over 65 the ALoS has reduced from 12.5 to 11.2 days and for those aged over 85 has reduced from 15.9 to 12.8 days. In the same period, the ALoS for patients subsequently transferred to a community hospital fell by five days from 20 days to 15 days. Bed days saved by the reductions in ALoS total 7692.

**Scheme 3.** Within community hospitals there has been a significant reduction in direct GP admissions. In the first 8 months of 1999 there have been 81 fewer admissions compared with the same period in 1998. This has been achieved with the agreement of local GPs who are now using RRICS. In addition, the ALoS for patients who continue to be admitted by a GP has fallen from 49 to 32 days. However, unfortunately there was an increase in ALoS for patients admitted from other sources not covered by RRICS. Altogether, an additional 108 patients were transferred from St Peters Hospitals in the 8-month period giving a saving of 540 bed days.

In total across the three schemes 13,770 bed days have been released equivalent to 56 beds. Of 779 referred to RRICS:

- 653 (83.8 per cent) were rehabilitated to full independence.
- 44 (5.6 per cent) continued to receive ongoing home care.
- 25 (3.2 per cent) patients were re-admitted to hospital.
- 24 (3.1 per cent) patients died (included palliative care).
- 31 (4 per cent) were placed in respite/rehabilitation (up to 28 days).
- 2 (0.3 per cent) were transferred to long-stay care.

Further reconfiguration through ‘RRICS and beyond’ is planned with the aim of optimising the health and well-being of frail older people by timely assessments of individual care needs and the provision of integrated community care to prevent crisis developing. Common assessment across health and social care will be at the core of improved service delivery, based on common assessment processes with agreed common information data sets.

Overall, the ‘RRICS and beyond’ initiatives are working to ten principles in developing better care for older people:

- Ensure easier access to care – one stop.
- Intervene early to reduce or prevent crisis.
- Focus on rapid expert assessments of appropriate complexity.
- Improve information flow through the system to aid continuity of care and avoid duplication of effort.
- Have networks of services that rapidly respond to need and are flexible.
- Blur organisational boundaries with shared resources and shared budgets.
- Seek the views of patients and carers proactively.
- Evaluate the outcomes and research new systems of care delivery.
- Practice the prevention of illness with health education.
- Keep reviewing the whole system to adapt to constant change.
The need for greater financial flexibility has also been recognised and has been assisted by new legislation. Arrangements that allow closer working are being strengthened following the consultation papers *Partnership in Action* [Ref. 10] in England and *Partnership for Improvement* [Ref. 11] in Wales. These papers set out the basis for shared health and social services arrangements, including the relaxation of rules about funding for health and social care. Until now, health and social services have been unable to pool their resources to any significant extent, hindering the development of integrated services. The *NHS Act 1999* [Ref. 12] now allows pooled funds, 'lead commissioning' and integrated provision. For rehabilitation services, which are funded and provided across agencies, these new arrangements could make a significant contribution to better co-ordinated care.

The new arrangements provide a real opportunity to ensure closer working between professionals delivering rehabilitation services through a better framework of joint working. The creation of community older people’s teams, complete with physicians, nurses, therapists, social care staff, etc could be one way to provide better integrated and linked services, provided a suitable system of governance can be devised. One possibility is a joint team under a single manager who holds the pooled budget and who reports upwards to a board made up of representatives from each agency contributing funds. Such a model would have an ‘hourglass’ structure [EXHIBIT 43].

**EXHIBIT 43**

*Governance arrangements for joint teams*

One possibility is a joint team under a single manager who holds the pooled budget.

*Source: Audit Commission*
Such a team could also eventually work across agencies and settings, replacing the model of Exhibit 2 with a new model linking services more closely, with the integrated joint re-ablement team moving to the centre [EXHIBIT 44].

EXHIBIT 44

A new model for linking services more closely

The integrated joint re-ablement team would move to the centre.

Source: Audit Commission
Rehabilitation improves the quality of life of older people who benefit from it. Even those who are going on to a residential or nursing home rather than back to their own homes are helped to live a fuller life. But is it cost effective, or is it likely to cost the NHS and local authorities more overall?

Rehabilitation costs more initially because it requires extra services – both facilities and staff. But it may be cost effective where the person who has been rehabilitated then needs less long-term care, or where the move from acute care to rehabilitation facilities releases acute beds. Do savings offset the extra costs? At present, it is difficult to say, but early indications are that they may.

For example, social rehabilitation units cost one-half as much as hospital places and can reduce the need for long-term care in residential and nursing home places. And community re-ablement teams reduce admissions and length of stay in hospital, and allow more people to return home.

However, the cost calculations are complex. Where people return home after rehabilitation rather than go into a home, they are still likely to need ongoing care and support, albeit at a reduced rate. The cost of rehabilitation and home care must be compared with the cost of residential or nursing home care. A higher risk of re-admission to hospital for those without adequate rehabilitation must also be taken into account. Long-term costs such as those required to fund the additional training of more therapists and other staff must also be factored in. And some account must be taken of different life expectancies for people who have returned to active life after rehabilitation.

It has not been possible to model all of these alternatives with their different costs and to come to any conclusion about overall costs, at this stage. However, studies outlined in this report have produced encouraging results.

The Audit Commission will continue to collect and update much of the data referred to in this report. It will eventually be available for a much larger group of authorities and trusts. Additional data will also be available, for example, about length of stay, hospital re-admission rates and the use of institutional care for those aged 75 and over. One possible way forward would be to build on the National Beds Inquiry – in effect, developing and costing the Inquiry’s third option of promoting a scenario involving care closer to home. Such an approach could provide an overall indication of the numbers of places in different forms of care and the numbers of staff needed, with costs and projections on the numbers of emergency admissions, lengths of stay and numbers of people returned home. The Commission would be pleased to work with the DoH, if necessary, to help provide such an analysis.
Improvements to rehabilitation services for older people require a complex, well co-ordinated approach. Lasting improvements will require all of the factors described in this report – good planning, a new understanding, a whole-systems approach, new flexibilities – and more. There are challenges to the professions directly involved. At first sight, the challenges of better organisation, multidisciplinary working and improved flexibility and skill mix may threaten some existing working practices. But the benefits for older people of rising to these challenges will be enormous.

**Conclusion**

Despite the difficulties and limitations of available information this report includes the following:

**BOX E**

A summary of evidence on costs and effectiveness

Despite the difficulties and limitations of available information this report includes the following:

The benefits from stroke units are achieved at no more cost than managing patients in non-specialist wards and units, according to the Stroke Unit Trialists’ Collaboration (Ref. 20).

Audit Commission/SSI evaluation of social rehabilitation schemes in Devon confirms that the schemes take people on the threshold of admission to long-term care and rehabilitate them to go home and that the results are lasting [CASE STUDY 18]. Independent evaluation by the University of York of a scheme in Rotherham found that six months post-discharge, 71 percent of those discharged home remained at home [CASE STUDY 2].

Unit costs for social rehabilitation schemes are around half those of community hospitals (£66.50 gross per day compared to £123 per day), but therapy input can be higher [BOX B]. However, longer overall lengths of stay mean that total costs are higher for such patients so it is important that ‘selection’ into such schemes is appropriately targeted on those who would otherwise be unable to return home [BOX B].

If appropriately targeted, the cost benefits of avoiding admission to long-term care would be considerable – the actual difference from long-term care costs depending, in part, upon ongoing community care costs. Earlier evaluations of the Devon schemes demonstrated low ongoing costs. Early evaluation of a scheme in Scarborough found that ongoing care costs were low, and that considerable net savings were achieved, compared with the equivalent cost of long term care costs [CASE STUDY 3].

The North Devon Re-ablement Service has achieved improvements for those aged over 75 with reductions in emergency admissions, in length of hospital stay, and the percentage of re-admissions [CASE STUDY 6B and EXHIBIT 17]. The initial funding for the service came from closing a local day hospital that was under-used.

A better use of therapy staff could help as the:

- use of assistants helped increase therapeutic activity and reduced length of stay in Bradford [CASE STUDY 14];
- use of an occupational therapist in an Accident and Emergency and Medical Assessment Unit in Haywards Heath helped to reduce the percentage of elderly patients admitted to wards [CASE STUDY 15]; and
- use of occupational therapists in the community helped reduce the costs of home care in Victoria, London [CASE STUDY 16] and in Nottingham. In Nottingham OT intervention also helped avoid admission to long term care [CASE STUDY 17].

Taking a whole-systems approach can deliver significant benefits, as in North West Surrey [CASE STUDY 18].
Developing A Strategic Approach

All of the factors involved need to be co-ordinated within an overarching strategy:

1. A shared approach and understanding between different parts of the health service and between health and social care is important.

2. Improved rehabilitation services require the close involvement of geriatricians.

3. All agencies within health authority areas will need to consider how best to come together to use such tools as JIPs to provide a framework for planning.

4. New financial flexibilities need to be used to set up new structures such as joint teams for older people.
Appendix 1

External advisory group

Betty Arrol  Age Concern
Mary Crawford  Independent Consultant (therapy adviser to the study)
Pam Enderby  Professor of Rehabilitation, University of Sheffield/
               Northern General Hospital, Sheffield
Tim Hill  General Practitioner, Shropshire
Irene Illott  College of Occupational Therapists
Avril Imison  Head of Policy, Therapy Services, Department of Health
Doug MacMahon  Consultant Geriatrician, Camborne/Redruth Community Hospital,
                Cornwall
Lindsay McLellan  Professor of Rehabilitation, University of Southampton/
                  Southampton General Hospital
John Pears  District Audit
Val Pomeroy  Senior Lecturer in Stroke and Therapy, Salford
David Raw  Inspector, Social Services Inspectorate (until August 1999),
           Independent Consultant, (from September 1999)
Owen Redahan  Stroke Association
Sheelagh Richards  Social Care Group, Department of Health
Janice Robinson  Director, Community Care, King’s Fund, London
Penelope Robinson  The Chartered Society of Physiotherapy
Deborah Rossiter  Royal College of Speech and Language Therapists
Martin Shreeve  Better Government for Older People
Alan Sinclair  Professor of Geriatric Medicine, University of Birmingham/
               Selly Oak Hospital
Gill Slade  Dorset Social Services Department
Michael Whitelaw  Medical Director, Riverside Community Healthcare Trust
               (Geriatrician adviser to the study)
Appendix 2

A. The impact of stroke

This report uses stroke, excluding transient ischaemic attacks (TIAs) as a tracer condition. The World Health Organisation defines stroke as ‘a clinical syndrome typified by rapidly developing clinical signs of focal (or global) disturbance of cerebral function lasting more than 24 hours or leading to death, with no apparent cause other than that of vascular origin’. The sudden onset of stroke, followed by major disability in many survivors, can be devastating for patients and families, and leads to high treatment and care costs for health and social services.

It has been estimated that stroke patients’ account for 20 per cent of acute beds and 25 per cent of all long-term beds, including nursing home places (Ref. 19). Stroke care in 1992–93 was 7.4 per cent of spending on community health care; 5.5 per cent of spending on hospital inpatient care; and 6.2 per cent of expenditure on social services (Ref. 53). A Stroke Association report estimates that overall, the costs of stroke care were just over £2.3 billion in England in 1995–96, 5.8 per cent of NHS and social services expenditure (Ref. 54). Furthermore, it has been estimated that expenditure could rise by 30 per cent in real terms by 2023 as the ageing population increases, and as the numbers needing longer-term support increase due to the reduction in the immediate mortality from stroke (Ref. 55).

The typical impact of stroke at a health authority level is illustrated in Box F. The data comes from an authority with a population of just under 500,000 covering a small city and the surrounding rural areas just outside.

BOX F

The impact of stroke in a health district

Stroke accounted for:

- Approximately 1400 admissions a year, meaning that on average, 80 hospital beds are occupied by stroke patients in the district.
- Around 12 per cent of all deaths.

Following stroke:

- 20 per cent die within the first month and a further 10 per cent within the first year.
- About 50 per cent of survivors are left with significant disability, commonly affecting mobility, speech and cognition.
- 16 per cent of survivors are discharged to nursing homes.

In nursing homes:

- Most residents (57 per cent) were admitted directly from hospital.
- Out of a total 55 homes, 19 had less than a 20 per cent complement of stroke patients, but 11 homes had over 30 per cent. The highest percentage was 45 per cent.
- The total annual cost of nursing home accommodation for stroke patients in the district was estimated (at £5 million in 1994) to be of a similar order to the total expenditure of the hospital and community health services on stroke.

Source: Audit Commission
Patient and carer satisfaction with stroke services has to be a key element in any evaluation of the quality of services. Research published in 1991 (Ref. 56) found that most stroke care came from informal sources and that formal services were poorly targeted and one-third of carers were under considerable strain. The authors concluded that it ‘is likely that better targeting of current resources’ could better satisfy patient and carer needs.

In 1994, Pound et al (Ref. 57) reported a high level of patient dissatisfaction with services. Just under half (48 per cent) of people were dissatisfied with some aspect of the care they received in hospital and over one-half (53 per cent) were dissatisfied with some aspect of the services they received in the community. The highest rate (54 per cent) of dissatisfaction was with the amount of therapy received (physiotherapy, occupational therapy and speech and language therapy). Most recently, a report specifically on patient and carer views of their stroke rehabilitation from the Intercollegiate Stroke Group (Ref. 58) found that while some had positive experiences there were also many criticisms. The report highlights the need for prompt access to knowledgeable staff who understand patient needs after a stroke, shared decision making, improved discharge arrangements and better information at home.

The Audit Commission as part of this review has developed a stroke user survey and The Way to Go Home uses findings from the pilot of the survey.

**B. The stroke user survey**

**Developing the survey**

Because of the problems involved in using a survey approach with stroke services users, the survey was designed so as to be as easy to understand and complete as possible.

The issues we chose to focus on are those found by qualitative research to be of greatest importance to users (Refs. 58, 59 and 60).

Drafts of the survey were initially developed using best practice in generic user survey and question design. We also took advice from academics experienced in working with dysphasics and people who had had strokes, which led us to phrase and format questions in certain ways, and include pictures to aid communication. Carole Pound, at City University, and the Stroke Association were very helpful at this point, and we are also grateful to the Pat Arato Aphasia Centre, Canada, for permission to use their pictures.
The survey was extensively piloted, in two stages. Firstly, extensive pretesting in one-to-one and group situations at Stroke Association Dysphasia Support groups and Stroke Clubs changed or eliminated some of the questions. Secondly, piloting of the full postal survey, using agreed sampling and checking methods, was carried out successfully at six sites across England and Wales. Altogether, 849 surveys were posted, 408 were returned and 385 of these were usable: giving a valid response rate of 45 per cent.

**Picking the sample**

The survey was sent to all stroke patients who were admitted to the acute or combined (acute/community) trust after a certain date, who:

- were of any age;
- were still alive;
- lived in the JIP area;
- had a hospital length of stay greater than 5 days;
- had returned to their own homes;
- did not live in a residential or nursing home; and
- had not been readmitted since.

**Contents**

The survey has 23 items, covering:

- hospital therapy – 5 questions;
- information provided in hospital – 1 question;
- equipment (Social services) – 2 questions;
- day and outpatients therapy – 5 questions;
- home-based therapy – 5 questions; and
- factual information – 5 questions.

The items can be grouped, to give feedback on the themes of:

- access to therapy and to specialist services;
- whether therapists asked them their views;
- whether they were given information about stroke; and
- continuity – how well handover to the community worked, in terms of readiness of equipment and of handover to community therapists.
Appendix 3

A. The roles of therapists

Occupational therapists (OTs), physiotherapists, and speech and language therapists (SLTs) carry out assessment and treatment to reduce impairment, disability and handicap.¹

**Occupational therapists**, employed by NHS trusts and social services departments, work with patients² to reduce physical or mental disabilities. Their general approach is to assess and reduce disability and handicap. For example, in work with older people they assess a patient’s ability to ‘do things’, for example, activities of daily living (ADLs). They then work with a patient’s existing physical impairments, encouraging them to improve their skills by practice (for example, dressing, or getting in and out of the bath), and teaching them new skills that allow them to perform tasks in spite of their physical impairments (for example, filling a kettle by standing the kettle in the sink rather than holding it).

OTs can assess the need for specialist disability equipment or adaptations, so that a patient’s home environment minimises the risk of accidents and enables patients to do as much as possible for themselves. The vast majority of social services OT work is in this area. For hospital patients, NHS-employed OTs usually assess equipment needs for discharge, with SSD OTs taking responsibility for major adaptations, although working arrangements vary between locations. The equipment provided ranges from tap grips to stair lifts to level-access showers.

Hospitals are required to set out procedures for discharge. OTs, especially in acute trusts where throughput is high, are heavily involved in ‘safe discharge assessments’ whereby patients deemed to be at risk are checked for their ability to return home before discharge. This check includes assessment of ADLs and mobility, transfers etc, and may include a home visit, where the OT accompanies a patient home (possibly with a social worker or other professionals) to assess the patient’s ability to cope, and the need for equipment and adaptations.

OTs, as part of their initial assessment of a patient, will usually undertake tests to check cognitive function (for example, tests of memory, or ability to solve problems) as well as physical disability tests. In some areas where there is no input from clinical psychologists, this may be the full extent of psychological assessment.

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¹ The World Health Organisation (1980) defined impairment as concerned with abnormalities in the structure or functioning of the body or parts of the body, characterised by anomaly, defect or loss of a part of the body (for example, loss of function in an area of cerebral cortex due to stroke; reduction in range of movement of arm); it defined disability as problems with the performance of activities, tasks and skills (for example, problems with activities of daily living like dressing, shopping); it defined handicap as the disadvantage that the individual experiences because of disability and impairment – the disadvantage in social circumstances (for example, loss of physical independence, occupation, social integration).

² OTs working in social services refer to their ‘clients’.
Physiotherapists employed by NHS trusts (and directly by GPs) work with patients to reduce impairments related to mobility and motor function. Physiotherapy is a healthcare profession which emphasises the use of physical approaches in the prevention and treatment of disease and disability.

Following a detailed assessment, which will include details of impairment, together with lifestyle and discussion of patient's goals, a management care plan should be drawn up.

A number of physical treatments may be used that are directed to reduce impairment and to improve function and mobility. An important element of the intervention will be to improve patient confidence and self-help strategies applied. Formal and informal carers should also be involved in the care plan to reinforce the therapy and maximise potential.

A regular assessment of the patient’s progress will take place and the care plan modified as appropriate. The patient and carers should be involved in this throughout the treatment programme. Preventative techniques need to be taught to ensure maximum mobility and motor function and help cope with untoward incidents, for example, a fall (techniques can be taught to enable a patient to get off the floor safely with the minimum of assistance).

Speech and language therapists (SLTs), work with clients of all ages to improve their language and communication skills. These may include difficulties caused by language delay in the case of children or disrupted language in the case of adults who have had a stroke. SLTs work with people who have reduced clarity of speech as a result of damage to the nerves and muscles of the voice, tongue, lips and face. They also play an important role in the assessment and management of swallowing problems, especially after stroke (dysphagia).

SLTs work in a wide range of settings, including hospital and community teams and in an educational context with children. In the field of stroke rehabilitation, SLTs work closely with their physiotherapist and OT colleagues as part of the multidisciplinary team to provide a functional approach, incorporating facilitation, strategies and re-education to maximise recovery.

A stroke can cause significant damage to the language centres of the brain (aphasia), which can give rise to a variety of problems. For example, some people have normal hearing but have severe problems understanding what is said to them as they lose the ‘meaning’ of the word. Others may understand what is said relatively well but are unable to select the right word to use and will say knife instead of fork or are unable to come up with any name. Some people may be able to use single words but have difficulty constructing sentences and they lose their knowledge of grammar.
As aphasia is a language problem, reading and writing may be affected in similar ways. Early assessment of any difficulties is necessary so that helpful strategies for communication can be put into place. An important role for the SLT is advising carers and other professionals how best to communicate with aphasic people.

People who have problems moving the organs of speech after a stroke (dysarthria), can be helped by massage, exercises and strategies to help increase intelligibility of speech.

**B. Calculating therapy inputs**

Within the report, to estimate the intensity of therapy, minutes per bed day have been calculated. The calculation used to arrive at the hours therapists spend directly in patient contact is based on an approach designed by Joyce Williams [BOX G].

---

**BOX G**

*Calculating Staffing Levels in Physiotherapy Services – Joyce Williams, 1991*

The underlying approach considers the work that can be dealt with by 1.0 whole-time equivalent (WTE) therapist. It calculates the ‘on-duty hours’ for that therapist:

- contracted hours (36 per week x 52 weeks) – 1872 hours;
- minus fixed leave at 7 weeks per year – 252 hours;
- minus sickness and maternity leave (2 weeks per year average) – 72 hours;
- minus study leave (5 days per year) – 36 hours; and

So – one therapist is on-duty for 1512 hours per year on average.

The time that this therapist actually spends on patient work is then calculated, based on Körner diary average times spent on patient work and other work. A WTE therapist works on average 70 per cent of time on patient-related work, so 70 per cent x 1512 = 1058 patient-related hours are available per year from that therapist.

From Körner diaries, of this patient-related time, 83 per cent is spent directly with patients – leaving 877 hours; the rest is spent on other patient-related work – 181 hours.

*Source: Joyce Williams (Ref. 45)*
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Older people are major users of health and social services. Many require more time than younger patients to make a full recovery. But rehabilitation services to help them are often patchy and disjointed. An integrated range of services is needed, linked by good care pathways and good organisation across professional and organisational boundaries.

*The Way to Go Home* argues that a more strategic approach is needed, to promote a shared understanding of what is required, and a whole-systems approach that looks at rehabilitation in the round and makes full use of new financial flexibilities.

At a time when new ways of organising healthcare are high on the agenda, *The Way to Go Home* proposes solutions that are of interest to primary care staff in health and local authorities, and the many professionals working in trusts. It should also be of interest to the many thousands of older people and their carers who depend on these services for their future quality of life.