Appendix 1

DRAFT STRATEGY FOR REHABILITATION AND RE-ABLEMENT WITHIN TELFORD & WREKIN

Purpose

This draft strategy sets out the proposed developments and changes to rehabilitation and re-ablement services in Telford & Wrekin. The overall aim is to provide a range of services that improve the quality of life for people and enable them to live as independently as possible. To achieve this, services must be timely, accessible and organised to meet individual needs.

This is a draft strategy. The NHS Telford & Wrekin and Telford & Wrekin Council welcome the views, comments and proposals from people in Telford and Wrekin, voluntary and independent organisations, public sector organisations and staff. Views of people who use the service and their carers are particularly important.

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Definitions

Rehabilitation:

The Department of Heath 'Transforming Rehabilitation Services' states:

"Rehabilitation services cover a wide range of essential support, from short interventions to longer term support for older people. For example, they help adults return to work after an illness and older people to live as independently as possible."

Historically services for people have been thought of in terms of the provision of health and social care services to look after those who have become ill, frail or disabled. It is only in recent years that the emphasis has shifted to focus more on promoting good health and sustaining independence. Coordinated multi agency rehabilitation is relatively new (the definition of rehabilitation can be traced back to post World War 2 years when there was a need to return service men to as near to a pre-war state as possible).

Re-ablement:

Home care re-ablement services provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves. Re-ablement can be described as an 'approach' or a 'philosophy' within home care services – one which aims to help people 'do things for themselves', rather than 'having things done for them'.

Home care re-ablement services fall into two broad groups:

'Discharge' re-ablement works predominantly or exclusively with people who have been discharged from hospital. Services can be selective, accepting only people likely to benefit from a re-ablement approach.

'Intake' re-ablement for people who meet local Fair Access to Care (FACS) eligibility criteria and are referred for home care services.

Home care re-ablement services are normally offered for up to six weeks, with some flexibility to continue for longer if the service user would benefit from this or if appropriate longer-term support services are not immediately available. Re-assessments and referrals for on-going home care and other services are made at the end of the period of re-ablement.

Overall Aim:

The overall aim of rehabilitation and re-ablement is to actively promote the restoration and improvement of a person's physical, emotional or social state lost or impaired through the effects of disability, disease or injury.

The Rehabilitation Council state: 'When individuals face challenges to their physical or mental wellbeing, they experience an impact on their quality of life. Rehabilitation (and re-ablement) is fundamentally about enabling and supporting individuals to recover or adjust

during this time, achieve their full potential and – where possible – to live full and active lives'.

Principles

This Strategy has been developed in keeping with the agreed principles and vision for all services in Telford & Wrekin. The principles that guide the development of rehabilitation and re-ablement can be summarised as:

1. Putting people at the heart of planning and developing services.
2. Adopting a person centred approach to service planning.
3. Integrating services across departments and organisations.
4. Increasing choice and control.
5. Prevention - supporting people before the point of crisis.
6. Flexible and inclusive– being able to change to meet diverse and changing needs of people.
7. Treating people and their carers with respect and dignity
8. Accessible – being clear about what services are available and how these are accessed.

Adopting these principles will help ensure services are designed and delivered to meet the needs of people while making the best use of all resources (staff time, equipment, buildings and funding).

These principles drive the overall proposals aimed at improving services for people:

1. Having a strategy and implementation plan for rehabilitation. This will set out the coordinated range of services that actively promote the restoration and improvement of a person's physical, emotional or social state while at the same time making the best use of all resources (staff time, equipment, buildings and funding).

2. Ensuring partners in health and social care are encouraged and enabled to deliver integrated rehabilitation in a variety of settings. This should include rehabilitation at home (including a residential or nursing home) to improve outcomes for the people who need the service, their families and carers.

3. Providing clear access criteria for services and information tailored to people's needs. This will help staff plan and manage care more effectively, ensure equity of provision and enable people who need the service to exercise choice and control.

4. Ensuring rehabilitation and re-ablement is person centred with a focus on maximising independence, health and wellbeing. The service must ensure people receive the right level of rehabilitation and re-ablement, in the right place at the right time.

People using the service.

All people have the same range of needs. The factors necessary to ensure independence and a good quality of life for everyone include:

Basic Needs:	Good physical and mental health Food and drink Housing Warmth Adequate income
Safety:	Protection from harm Law and order
Belonging:	Family/friends Love and affection Companionship and shared interests
Being Valued:	Development and achievement Respect and recognition Contribution Ability to make and carry out own plans Status and responsibility
Enjoyment:	Learning and knowledge Appreciation of art, drama, dance, the written word, sport etc
Fulfilment:	Reaching full potential Being a member of the community Citizenship

The above list demonstrates that, people have needs much wider than just health and social care. The focus of all services should be to encourage and support people to remain active citizens within their communities while ensuring the right services are available to people at times of need.

Rehabilitation can be required at any age in life. However, the majority needing the service are older people. Older people make an important contribution to the life of our local community. They are the mainstay of many community and voluntary groups and play a vital role in supporting family and friends as carers. However, their contribution often goes unrecognised and stereotypes of old age, as a time of dependence and incapacity, tend to exclude older people from mainstream activities and devalue their knowledge and views. Although the ageing process presents many challenges, older people are able to live fulfilling lives and enrich the life of their local community.

People are living longer and with this comes the expectation that the period of fulfilling, independent living will increase to match. This can be achieved by the development of approaches which aim to 'add life to years' as well as 'years to life'(Department of Health).

As a new town established in the 60's, Telford continues to expand and has the fastest

growing population in the West Midlands. At present it has a younger than average population. Telford will over the next 10 – 20 years, have a significantly larger increase in the older population than the national average. For example, over the next 5 years 65 to 69 year olds will increase by 4,000 from 5,900 to 9,900 (68%).

By 2020 over half of the population will be over 50 and there will be fewer young people. In addition the post war generation have higher and different expectations of public services than previous generations. This change in the population has many implications for public services in how services are developed and delivered.

Details of the needs of people in Telford & Wrekin are set out in Appendix 1, under the headings:

The Population
Health and Care
Chronic Health Conditions
Falls and Accidents
Stroke
Dementia
Brain Injuries
Multiple Sclerosis

This list is not intended to exclude people with other conditions who need rehabilitation. The Strategy for Long Term Conditions details the proposals for neurological conditions.

Maintaining Independence

People want to remain independent for as long as they can. Many devote a great deal of time, thought and energy to maintaining good physical and mental health. There are, however, events in people's lives that have an impact on their ability to cope and remain independent. These include:

Internal causes of dependence

Physical and mental ill health and disability can seriously affect a person's ability to go about their everyday life in the way they choose. It is often the direct effects of the illness or disability which restrict a person's ability to do things and also the psychological impact of incapacity, such as depression, low self esteem, demotivation and loss of confidence and self efficacy (the sense of control over your own life).

External causes of dependence

External circumstances can also cause loss of independence and quality of life. These include:

- The environment e.g. poor housing, inaccessible facilities in the home and public places, unsuitable public transport arrangements etc.
- Poverty
- Crime
- Ageist attitudes which devalue older people and have the effect of excluding them from services and denying them the opportunity to participate in and contribute to their community, further impacting on their self value.
- Bereavement

Health, Social Care and the broad range of services available should all aim to promote independence.

Although the risk of illness and disability increases with age, there is much that can be done to prevent or delay loss of health and independence. Services need to be redesigned to place more emphasis on helping people to maintain their health and independence. Put simply, services need to be focused on 3 main areas:

Prevention – to enable people to maintain good physical and mental health and live independent and fulfilling lives as part of their local community.

Rehabilitation and Re-ablement – to assist people who have experienced illness, or other setbacks affecting their quality of life, to return, as far as possible, to their preferred way of life.

Care – to support people whose health and ability have been permanently impaired, whilst maintaining the abilities they still have and ensuring that they retain control over their way of life.

This strategy covers the rehabilitation and re-ablement part of this system.

The Current Position

The position of current services can be summarised as:

Planning Services

Some key joint strategies and plans have been agreed. These include: Strategy for Older People, Long Term Pysical and/or Sensory Disabilities, Acute and Emergency Care and the Health and Well - being Strategy. Taken together these set out the vision, principles and (to some degree) the priorities for development. These are a good basis for joint understanding, commitment and working together.

Overall there has been some good joint work to plan service changes for people and to a lesser extent rehabilitation. This strategy and the implementation plan that follows must make it clear:

- how these plans were implemented
- who was responsible for making it happen
- how the budgets followed/enabled the changes
- how progress was monitored and adjusted in the light of experience.

Community Services

There are a variety of services in the community, including:

- Assistive Technology (eg community alarms)
- British Red Cross 'StayWell' Service
- Community Classes (eg exercises)
- Community Equipment Services
- Community Nursing Team (Including specialist Nurses and Health Visitors for the Elderly)
- Community Physiotherapy
- Domiciliary Care Providers
- Falls Prevention Service
- General Practices
- Headway
- Health Promotion, Community Exercise Classes, 'Women in Motion', Walk-about-Wrekin'.
- Home Improvement Agency and 'Handy-Man' Service to assist with adaptations
- Intermediate Care Services:
- Early Supported Discharge
- Rapid Response
- Community Assessment Support Service
- Intermediate care beds
- Interim care beds (to aid discharge from hospital)
- Independent Living Partnership
- Local Authority Occupational Therapy

- Low Level Services, including Community Meals
- Moving and Handling Service
- Paul Brown Day Hospital
- Stroke group
- Shropshire Enablement Team
- Speech and Language Therapy
- Social Work Assessment and Care Management Teams
- Social Inclusion (prevention and rehabilitation)
- Shropshire Wheelchair Service
- Telford Rapid Access Services for the Elderly (TRASE)

Although these offer excellent patient care, they are not well coordinated, there is lack of capacity and disparity between location and the age of the person who can receive the service.

Shropshire Enablement Team and the Community Physiotherapy Team

Service Reviews of Shropshire Enablement Team (SET) and the Community Physiotherapy Team (CPT) were completed in January 2010. Some common issues emerged from both reviews and these include:

1.Areas of good practice and evidence of standardised quality care being delivered but not being captured or collated through a robust performance management framework.

2.The care pathway through services from Acute – Community requires improvement.

3.Rehabilitation referrals and Care Pathways in the CPS/SET services need further work to ensure the service user gets treatment from the correct rehabilitation service

A stronger focus on collecting and collating feedback from service user's experiences is needed.

Areas for improvement are summarised as:

1. The need to create a stronger local vision for Community Rehabilitation therapy services in Telford and Wrekin.
2. The need to develop a more cohesive localised referral process and clarify clinical pathways to access community rehabilitation in Telford and Wrekin
3. The development of a Performance Management Framework that includes a system for reporting and monitoring service delivery

Inpatient Rehabilitation

The inpatient service is provided by the Princess Royal Hospital, mainly on Wards 15 and 16. The staff on the wards impress as being really committed, helpful and genuinely concerned about patient care.

There are some very positive aspects of rehabilitation on the wards, including:

- The newly introduced stroke care pathway
- The planning meetings held with relatives of stroke patients
- The multidisciplinary team meetings
- The commitment and care of staff
- The assessments and plans and interventions of the therapy services

Other aspects of rehabilitation need to be developed, including:

The involvement of carers in the assessment, care planning and guidance/training to support discharge and post discharge care.

A consistent approach to:

- The psychological and psychiatric needs of patients.
- Personalised care plans for each patient that include actions to address their medical, physical, cognitive and motivational needs.
- Discharge planning from the time of admission.
- Social work involvement in all cases.

View of local people.

In 2008, a Strategic 'Thinking Ahead' project working group was established to steer and coordinate the health and social care review work on rehabilitation and re-ablement. This incentive for re-design was driven by national and local policies, needs-based evidence arising from the Joint Strategic Needs Assessment, and the experience of people and patients living in Telford & Wrekin.

The key findings of the review were:

There are a variety of services that are offering excellent care but these services do not often seem joined up, which creates confusion for the people using the service and staff, as they attempt to navigate a complex system
.
Access to a coordinated pathway for rehabilitation is patchy and dependent on a discharge pathway from the acute hospital and the services that people find themselves referred to.

Some services are not age inclusive and there is disparity between service levels dependent on where patients live within Telford & Wrekin.

Lack of capacity in some services also makes access to certain facilities, either not possible, or time-limited for some patient groups.

There is a sense of missed opportunity in areas that could, with investment and development, ensure a far more coordinated and effective pathway for rehabilitation.

The findings of this review are vital for planning services, as to be effective, the action taken to achieve the best service possible must be rooted in the experience and expectations of people themselves. People requiring rehabilitation and re-ablement are the experts on their needs and are best equipped to identify what should be done to improve their lives.

Planning Rehabilitation and Re-ablement

The White Paper, 'Our Health, Our Care, Our Say', outlined a vision for health and social care services which included:

- High quality support services meeting people's aspirations for independence and greater control over their lives
- Services which are flexible and responsive to people's needs
- The shift to a greater emphasis on prevention

It defined 7 outcomes to be achieved by the services provided:

1. improved health and emotional wellbeing
2. improved quality of life
3. making a positive contribution
4. choice and control
5. freedom from discrimination
6. economic wellbeing
7. personal dignity

The government plans (2010) are set out in the document: 'Equity and Excellence: Liberating the NHS.' This stresses:

1. Patients will be at the heart of everything we do
2. There will be a relentless focus on clinical outcome
3. We will empower health professionals

These ambitions are at the core of all the proposed developments for the NHS. When considering the future of rehabilitation and re-ablement the proposals in 'Liberating the NHS' must be taken into account. These include:

For patients:

Focus on personalised care that reflects individual's health and social care needs, supports carers and encourages strong joint arrangements and local partnership

Enable people to have greater control over their care and support so they can enjoy maximum independence and responsibility for their own lives

"Shared decision making" to become the norm. Involving people in their care and treatment improves their health outcomes

Patients and carers will have far more clout and choice. The NHS will become more responsive to their needs and wishes

Do not see choice as just about where you go and when, but a more fundamental control of the circumstances of the treatment and care you receive

Funding:

Money will follow the patient through transparent, comprehensive and stable payment systems.

Providers will be paid according to their performance

Devolve power and responsibility for commissioning services to the healthcare professionals closest to the patient: GPs and their practice teams working in consortia

Seek to break down barriers between health and social care funding to encourage preventive action

Personal health budgets: evidence shows these have much potential to help improve outcomes, transform NHS culture by putting patients in control and enable integration across health and social care

Joint working:

Critical interdependence between the NHS and adult social care systems in securing better outcomes for people, including carers

NHS Outcomes Framework will span:

Effectiveness of treatment
Safety and care provided
Broader patient experience

Essential for patient outcomes that health and social care services are better integrated at all levels of the system

Achieving the above requires a person-centred approach which focuses on maximising independence, health and wellbeing. This can best be achieved by providing a range of integrated services to ensure people receive the right level of rehabilitation and re-ablement, in the right place at the right time.

Rehabilitation and re-ablement must also:

1. Be provided when needed and before a decision about long term care is made.
2. Cover both physical and psychological needs.

These two requirements are detailed below.

1. Be provided when needed and before a decision about long term care is made:

It has been found that most older people seeking assistance from adult social care do so after a crisis of some kind, which makes them and/or their carers feel that they can no longer cope. The crisis is often an illness, injury or fall or a sudden event such as the death of a partner or experience of crime. This usually represents a low point in the person's life. A period of recovery, rehabilitation and rebuilding of confidence is usually needed before longer term care and support needs can be accurately identified.

This is, therefore, not a good time to finalise an assessment of needs or make decisions about the person's long term future. The first priority should be to put in place the short term interventions to establish the extent to which the person's capacity for self care can be restored. These interventions have a better chance of being effective if they take place as soon as they are needed. This would have a number of advantages:

> The ultimate long term care will be the best match for their needs; will be designed with them and their carers and will therefore have a better chance of succeeding
>
> After rehabilitation, It may be possible to remove the need for ongoing care, and to establish independence and coping skills more effectively so future crises can be avoided.
>
> People with ongoing care needs would be in a much better emotional and psychological state to decide for themselves how they want those care needs to be met and would, therefore, be more likely to be satisfied with the arrangements made in the long run.

2. Cover both physical and psychological needs:

To be effective rehabilitation and re-ablement must be based on the individual's experience of the ageing process and the complex interrelationship between physical and psychological processes. Although old age offers opportunities for personal development and growth, it also carries with it increased risk of loss and traumatic events such as outlined above.

There is evidence that:

> Older people suffering from ill health and disability are twice as likely as those in good health to suffer from depression. This is usually related to the impact their health problems have on their capacity to undertake every day tasks and maintain their social networks.
>
> The onset of depressive symptoms and anxiety initiate a downward spiral, resulting in further reductions in activity and social interaction, leading to poorer health and a worsening mental state. Depressed older people are at high risk of increased physical disability and functional decline.
>
> Depressive mood together with poor physical function causes progressive impairment in the physical and psychological health of older people.
>
> Mortality and morbidity are more strongly related to the experience of control over

one's own life than exposure to health risks, per se

Rehabilitation should focus on preventing or delaying this downward spiral of increasing dependence, declining physical and mental health and poorer quality of life. Interventions need to address physical aspects (e.g. mobility, physical functioning, pain management etc) and mental health and the factors which promote it (e.g. social relationships and support, self esteem, self efficacy).

This approach has benefits for the individual and the services. Depression impairs social and physical functioning and increases the risk of experiencing other illnesses. This has a cost not only in terms of pain and suffering for the individual, but also for care services. The cost to services is detailed in the Finance Section of this strategy.

Evidence of best practice

The specific actions set out in the section ‘Proposals for Rehabilitation in Telford and Wrekin’ are based on the evidence of best practice and guidance from:

1. The Department of Health programme ‘Transforming Community Services’.
2. The study of short term outcomes and costs of Re-ablement Services.
3. ‘Putting People First’.
4. The finding of the local Strategic ‘Thinking Ahead’ project working group

Appendix 2 details the evidence of best practice set out under the studies and reports:

Transforming Rehabilitation Services:

Finding of The Department of Health programme ‘Transforming Community Services’ which aims to improve quality and productivity and ensure the best service for patients and their families.

Re-ablement Services:

Findings of a study of English local authorities with responsibility for adult services who are developing short-term, specialist home care-based re-ablement services.

Partnership for Older People Projects:

Findings from the national Partnership for Older People Projects (POPP) programme (DH 2010) provided examples of efficiency savings linked to developing more effective ways of using resources whilst also improving quality.

University of Birmingham:

The University of Birmingham researched rehabilitation services and identified 500 studies of good practice.

Health Service Management Centre:

The Health Service Management Centre (Birmingham University) and the Strategic Health Authority findings in a report entitled: ‘Reducing unplanned hospital admissions.

Finance

Efficiency

The Department of Health document “Transforming Rehabilitation Services” states that Quality is fundamentally linked to efficiency: Doing things right the first time so they don’t have to be done again.

This not only makes sense in terms of efficiency, but also peoples’ experience of the care they receive. That is why quality and productivity must go forward together.

“A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It’s when things go wrong they become expensive and inefficient.” (Transforming Rehabilitation Services).

Services must be well planed and provided in order to make the best use of all resources (staff time, equipment, buildings and funding). This will ensure people receive the full benefit of the money available to pay for services without seeing any loss through overlap, duplication or inefficiency.

The Value of Rehabilitation

Rehabilitation that helps someone to recover and achieve their full potential is, of course, good for the person concerned and their family. It is also a good investment for health care and social care, including:

Preventing decline.

As detailed in the section ‘Planning Rehabilitation and Re-ablement’, rehabilitation must be based on the individual’s experience of the ageing process and the complex interrelationship between physical and psychological processes.

Depression impairs social and physical functioning and increases the risk of experiencing other illnesses. This has a cost not only in terms of pain and suffering for the individual, but also for care services. It has been found that:

> the healthcare costs of depressed medical patients are twice that of non-depressed patients with similar levels of medical morbidity and
>
> those who are depressed have more than twice the number of hospital days over the expected length of stay

depressed older adults in an inner city primary care clinic made 38% more visits than those without depression, leading to additional costs on the service of 61%.

the usage of health and social care services by depressed older people was 3 times greater than for those who are not depressed.

Rehabilitation which addresses the mental and physical state of people at risk of further decline will, therefore**,** improve their independence, health and quality of life and ensure the best use of expenditure on health and social care services.

Long term care (including nursing and residential care).

Following rehabilitation some people may still need long term care either at home or in a residential or nursing home. It has been found that most older people seeking assistance from adult social care do so after a crisis of some kind, often an illness, injury, fall or bereavement. A period of rehabilitation and rebuilding of confidence is usually needed before longer term care and support needs can be accurately identified.

Rehabilitation for these people has a number of advantages:

The ultimate long term care will be the best match for their needs

It may be possible to remove the need for ongoing care

People would be more likely to be satisfied with the arrangements made in the long run.

NHS Continuing Health Care.

Rehabilitation is particularly important in terms of the financial cost of NHS Continuing Health Care. The guidance on Continuing Care stresses that before making the decision that a person meets the criteria for continuing care, consideration should be given to a persons 'further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs'.

An investment in rehabilitation should have an impact on the number of people meeting the criteria for Residential/Nursing care and NHS Continuing Health Care. Rehabilitation can contribute to:

Reducing the risk of people declining further
Reducing the need for long term care/Continuing Care

This would ensure the best use of funding and provide a better service for people.

Current Funding

Rehabilitation and re-ablement are funded by the PCT and the Adult Social Care budget of the LA. These overall budgets for 2010/2011 are:

Primary Care Trust

Income:	Department of Health Allocation		£266 M
Allocation:	Commissioned services	SaTH	£81M
		Other NHS	£49M
		Specialist Services	£27M
		Continuing care	£14M
		Partnership/Grants	£7M
		Other commissioned	
£5M			
	Primary Care	General Medical Service	£22M
		Prescribing/Pharmacy	
£31M			
		Dental	£9M
	PCT Allocation	Corporate Services	£7M
		Contingency/development	£14M

Local Authority Adult Social Care (gross expenditure)

Income:	Council Base Budget	
£35M		
	Specific Grant	
£1.4M		
	Client Income	
£5.8M		
	Miscellaneous Income	£0.08M

This draft strategy emphasises the need to develop community services. This will inevitably require a redistribution of finance. Through joint commissioning, the LA and PCT must ensure that services are commissioned based on:

- Evidence of need
- Evidence of best practice and effectiveness
- Principles of best value
- Clear and transparent financial planning and management
- Locally agreed and determined priorities
- Robust risk management

The overall aim is to:

Maximise the benefit from an effective joint planning arrangement between Health, Local Authority and Voluntary Sector through common focus of work and consistency of approach.

Ensure commissioning arrangements maximise the use of both the Local Authority and Primary Care Trust budgets, and budgets are combined where this adds value and achieves greater benefit.

Proposals for Rehabilitation in Telford and Wrekin

These proposals are based on the principles for Telford and Wrekin, the views of local people, the Governments proposals and the evidence of best practice. They contribute to the Local Authority and Primary Care Trust agreed purpose:

> ‘to develop local services which will assist and support people in Telford & Wrekin to remain independent in their own homes for as long as possible, will improve their quality of life and to set out a strategic approach to developing services which are timely, appropriate and accessible for people as and when they need them.’

The actions will improve the services for people who use them by:

1. Improving the service planning arrangements in order to make the best use of all resources (staff time, equipment, buildings and funding). This will ensure people receive the full benefit of the money available to pay for services without seeing any loss through overlap, duplication or inefficiency.

2. Making the best use of health and social care services by delivering integrated rehabilitation in a variety of settings including at home.

3. Establishing a single system for rehabilitation that identifies those people who would benefit from rehabilitation, coordinate their assessments, agrees the most suitable provision and its location (community or hospital)

4. Providing clear information about the full range of rehabilitation services available. This will help staff coordinate care and people/carers to have choice and control

5. Providing access criteria for all rehabilitation services to help people and carers exercise choice and the equitable distribution of resources based on priority of need

6. Ensuring plans for rehabilitation cover the psychological and emotional needs of people as well as their physical state. Plans will be developed with the patient and their relatives/carers and provide clearer information about proposed plans for rehabilitation and care.

7. Ensuring carers’ support is built into the design of the rehabilitation and they will be supported in their role in order to aid a patient’s recovery and rehabilitation.

This model for rehabilitation and re-ablement is show as a diagram on the following page.

Illustrative Model

(created following event April 2009)

putting people first in Telford and Wrekin

Telford & Wrekin COUNCIL

Review Assessment & Evaluation

Prevention
Case-finding
Health & Social Care

Event/ Crisis/ Stroke
Breakdown of services

Intervention

Rehab/ Recovery

Maintenance

Enablement

Re-ablement

Level 5
Severe Dependence

Level 4
High Dependence

Level 3
Moderate level of Dependence

Level 2
Degree of Dependence

Level 1
Degree of independance

As independance decreases

As independance increases

LEVEL 1
(There is an opportunity to maximise and regain full independence).
- Re-ablement – shopping
- Regaining movement
- Brief Intervention
- Falls – exercise classes
- Meals

LEVEL 2
(Needs some assistance to carry out activities of daily living).
- Minimal deficit
- Cognitive
- Sensory
- Motor
- Speech and language
- Functional well-being

LEVEL 3
(Needs significant assistance to carry out the activities of daily living).
- Significant mobility problems (wheelchair/ equipment).

LEVEL 4
(Without intervention there is little or no choice or control over their daily living).
- Multiple deficits
- Significant impairment
- Unable to stand unaided
- Assistance of 2 to transfer

LEVEL 5
- Maintenance of dignity

Optimising choice at point where people need maximum intervention from services.

Daily Living
- Education
- Relationships
- Leisure
- Work
- Learning
- Volunteering
- Personal / Domestic Routines
- Mobility
- Personal Safety
- Dignity, personal care
- Nutrition

Proposed Actions:

The proposals are set out under the headings:

Planning Services
Working Together
Choice and Control
Care planning and case management

Planning Services

Services must be well planned in order to ensure rehabilitation actively promotes the restoration and improvement of a person's physical, emotional or social state while at the same time making the best use of all resources (staff time, equipment, buildings and funding). This will ensure people receive the full benefit of the money available to pay for services without seeing any loss through overlap, duplication or inefficiency. This may include the redesign, commissioning or decommissioning of services. The specific actions to achieve this are:

1. Service users, carers and the third sector will be directly involved with development of rehabilitation services. Developments must draw on their experience as well as the wealth of knowledge of service providers.

2. A joint group will be given a clear brief to consult on the draft and propose the final strategy for rehabilitation. Public Health and population projections must be taken into account when developing the final strategy and implementation plan.

3. The implementation plan will be prioritised, timed, costed and have clear monitoring arrangements.

4. Based on the strategy and implementation plan, a number of Service Specifications will be agreed between those commissioning the service and those providing the service. These will clearly set out :

   Service aims
   Objectives
   Service requirements
   Funding
   Monitoring

5. The emphasis will be the development of community services to form part of the range of services. The DH state that a number of studies suggest that home based rehabilitation is just as effective in delivering improved functioning. However, it was also noted that home based rehabilitation may place additional demands on carers and therefore

consideration needs to be given to supporting carers and provision of regular respite care

6. The strategy group for rehabilitation will consider how best to:

   involve the local community in rehabilitation
   reach those who may be marginalised from society

7. The use of technology to support and sustain rehabilitation will be included as an integrated part of the rehabilitation strategy.

8. The implementation plan for the strategy must consider the relative priority of sustainable funding for Care & Support Technology if the service is to be maintained and expanded (all provision to date has been via time-limited capital funding)

9. The vital role of education and training will be included as an integrated part of the implementation plan

Working Together

The strategy and implementation plan will enable and encourage partners in health and social care to deliver integrated rehabilitation in a variety of settings. This should include rehabilitation at home (inclusive of care homes, social services settings) to improve outcomes for the service user, family and carers. This will need to identify the competencies required to provide sound services in the home, in hospital and other settings.

People have the right to receive the best service that can be provided. This will be achieved if health and social care services work together across professional and organisational boundaries:

> "Efficiency and prevention are about ensuring that the right person is brought into the right part of the system at the right time. Not only is this the way to deliver greater efficiency and a clearer focus on prevention, it also secures the best outcomes for people." (Department of Health 2009).

> "NHS organisations must continue to develop working arrangements with local authorities; partnership is no longer an optional lever – this is absolutely imperative if we are to achieve gains across public services." (Department of Health 2009).

The specific actions to achieve this are:

10. There will be a single system for rehabilitation in Telford and Wrekin that:

    Identifies those people (within the hospital and the community) who would benefit from rehabilitation
    Coordinates their assessments
    Agrees the most suitable provision – including location (community or hospital)
    Oversees the coordination of services
    Ensures services are accessible to those in greatest need

A single system is being considered for prevention/anticipatory care that:

Indentifies those people who are at risk and would benefit from intervention/prevention.

Coordinates their assessment.

Agrees the most suitable provision including the location of the service to be provided.

Provides or Oversees the coordination of services across health, social care and the independent sector

Ensures services are accessible to those in greatest need and targeted on those able to benefit most from the assessment and intervention

The advantages and disadvantages of having one single system for rehabilitation/re-ablement and prevention/anticipatory care should be considered and a decision made about the best way forward.

11. There will be clear information about the full range of rehabilitation services available. This will help staff to coordinate care and patients/carers to have choice and improve control.

12. A system will be established to make the best use of rehabilitation specialists across organisations and professions. This will help promote a culture of rehabilitation for all patients and develop the skills and knowledge of non specialist workers. The need for changes in roles/new roles will then be established and implemented.

13. The practice of discharge planning will be reviewed with an emphasis on action required to enable discharge, clarity of responsibility, timescales and patient/carer involvement. Discharge planning should start as soon as possible, ideally on or prior to admission. The recently

introduced stroke care pathway and patient/carer involvement should be evaluated to establish how effective this has been and which features can be used in non stroke rehabilitation.

Choice and Control

The DH state that several studies suggest that helping people to take responsibility for their own rehabilitation and recovery is essential. One way of achieving this is through the provision of clear and accessible information. The specific actions to achieve this are:

14. People and carers will be provided with tailored information. This needs to be easily accessible, inviting and needs to encourage people to apply the skills and actions to their daily activity. Written materials to support self management can help but if used alone they may have little effect on behaviours, health outcomes or service use. Familiarisation or educational sessions to enable self management are also required.

15. The provision of equipment will be reviewed to ensure it is prioritised to meet the needs of those in greatest need who would benefit the most.

16. Access criteria for all the components of the rehabilitation service will be agreed. This will enable:

    The identification/selection of those people (within the hospital and the community) who would benefit from rehabilitation

    People and carers to exercise choice

    Staff to know how the system works and therefore manage patient/user/ care/flows more effectively

    The equitable distribution of resources based on priority

    The identification of gaps and duplication in service

Care planning and case management

Achieving the best rehabilitation requires a person-centred approach which focuses on maximising independence, health and wellbeing. This is achieved by providing a range of integrated services to ensure people receive the right level of rehabilitation, in the right place at the right time. To be effective this must be based on the individual's experience of the ageing process and the complex interrelationship between physical, social and psychological processes. The specific actions to achieve this are:

17. The system for agreeing and recording care plans will be revised to ensure they are specific for each individual. This should greatly aid a clear, timed and effective process for rehabilitation.

18. Assessments and care plans will systematically address the psychological, emotional, social and physical needs of people to ensure they recover or adjust and achieve their full potential and – where possible – live full and active lives

19. Carers' support will be built into the design of the rehabilitation and they should be supported in their role in order to aid a patient's recovery and rehabilitation.

20. The administrative system that support rehabilitation should be designed to avoid duplication, free staff time for direct work with people and provide clearer information about plans and care.

Conclusion

The proposed actions are aimed at improving the services for people who use them by:

1. Improving the service planning arrangements in order to make the best use of all resources

2. Making the best use of health and social care services by delivering integrated rehabilitation in a variety of settings including at home.

3. Establishing a single system for rehabilitation that identifies those people who would benefit from rehabilitation, coordinate their assessments, agrees the most suitable provision and its location (community or hospital)

4. Providing clear information about the full range of rehabilitation services available.

5. Providing access criteria for all rehabilitation services to help people and carers exercise choice and the equitable distribution of resources based on priority of need

6. Ensuring care plans are developed with the patient and their relatives/carers and cover the psychological and emotional needs of people as well as their physical state.

7. Ensuring carers' support is built into the design of the rehabilitation and they will be supported in their role

8. Measuring Progress

It is essential to measure progress over time and use data to inform service changes and commissioning. The data used to measure progress will be agreed with the implementation plan and should include:

Top quartile performance or a strong reducing trend on:

1. Emergency admissions per head of population
2. Admissions to long term care per head of population
3. Achieving independence for older people through rehabilitation/intermediate care
4. Incidents of fractured neck of femur
5. Number of long term placements made straight from hospital
6. Proportion of overall budget spend on institutional care

Maximising Independence Targets:

Measure	Target
No. and % of referrals routed through rehab	80-95% of referrals
No. and % of intake not requiring ongoing support after rehab	60%
No. and % of intake requiring ongoing support after rehab (reduced package)	30%
No. and % of intake requiring ongoing support after rehab (maintained or increased package)	10%
% improvement in outcomes for the individual	To be determined
No. and % of intake who not complete their activity plan	Under 10%
Average cost per person for reablement	£2000
Average duration in reablement service	6 weeks
% of time spent directly with client on reablement activities	60%
Ratio of frontline staff to individuals receiving reablement	1 to 3
Reablement cost per client hour	£41/hr
Reablement cost per hour	£22/hr
Average length of independent living before re-entering support services	Up to 2 years
No. and % of those who receive reablement who return with further service requirements within 4-6 months (breakeven)	Under 10%

Results from client surveys (further work required):
No. of people surveyed/% satisfied/% neutral/% dissatisfied

Appendix 1

People in Telford and Wrekin

There are significant pockets of socio/economic deprivation in Telford and Wrekin with many people living on low incomes and with poor access to services in the more rural areas

The 2001 Census found that there were:

- 19,628 people aged 65+ residents in the Borough
- 14,874 (76%) were aged between 65 and 79 years
- 4,121 (21.0%) were aged 80 to 89 years
- 633 (3.2%) were aged 90+
- There are more females (54.5%) than males (42.2%).

From the 2001 Census to 2016:

- The number of people aged 65+ will grow by some 8,471 (43.2%) and increase as a percentage of the population from 12.4% to 15.5%.
- The greatest change will be in the 65 to 69 year olds who will increase by 4,000 people from 5,900 to 9,900 (68%).
- The greatest relative change will be in the number of residents aged 90+, which will increase by 500 people from 600 to 1,100 – an 80% increase. This is the group of people most likely to require some level of support from services

The age structure of the area's black and ethnic minority (BME) population is younger than the area's total population: just 1.9% of the 65+ population are of a BME background compared to 5.2% for the total population. This rate is also much lower than the national 65+ profile where 2.9% of the population are from a BME background. It is important to establish the ethnic and religious composition of the population because services which are sensitive to the different needs of a range of cultures must be delivered. Different groups will, of course, have different needs.

The number of BME residents aged 65+ will increase from 378 in 2001 to some 665 people by 2016.

Health and Care

Of the 65 years and over population:

- just under a third described their health as "good"
- a further 43.1% as "fairly good"
- just over a quarter (26.6%) "not good".
- men were more likely to report that they had "good" health than women (34.9% and 28.6%).
- just over a fifth of 65 to 74 year olds reporting that their health was "not good" compared to 37.9% of the 85+ group.

- significantly more people aged 65 and over stated that they had a limiting long-term illness Just over a half (55.1%) of the 65+ population had a long-term lifelimiting illness - considerably higher than the area-wide rate of 18.0%.
- 11.3% of the 65+ group provide unpaid care to friends or relatives – this rate is slightly higher than the area-wide rate of 9.9% but the same as the England rate.
- Older people are much more likely to provide a greater number of hours of care: 2.4% of 25 to 65 year age group provide 50 or more hours of care a week compared to 4.8% of the 65+ group.
- Within the 65+ group males are more likely to identify themselves as providing care than females (13.2% and 9.8%). This gender difference was greatest for the 85+ group in which just 1.7% of females provide care compared to 8.4% of men.

Chronic Health Conditions

Chronic diseases are diseases which current medical interventions can only control not cure. The life of a person with a chronic condition is forever altered – there is no return to 'normal'.

- 60% of adults in England report a Chronic Health problem. The numbers of people with chronic health conditions is rising and continues to do so.
- 45% of those with chronic disease are likely to have more than one chronic condition, over 65 this rises to nearly 70% or 19,670 people in Telford by 2016.
- Around a quarter, 7025 will have 3 or more problems making their care needs far more complex. The more diseases you have the more likely you are to have difficulty with usual daily activities.
- The Census reported over 14,000 65+ who identified themselves as having a long term limiting illness
- Xxx % of the population suffer from dementia. The Care Services Minister has said "The current system is failing too many people with dementia and their carers".

Falls and Accidents

The highest death rates from falls and accidents are seen amongst older adults in the 55-64 years and 65+ year age groups. Age specific death rates in people aged 55-64 years in Telford & Wrekin during 1999-2003 are significantly higher than the national average for England & Wales.

Many older adults fall:

- over 30% of people over 65, 8,430 by 2016 have a fall in any one year and the percentage increases with age.
- Falls account for 71% of all fatal accidents to those aged 65 and over, and 54% of all injuries.
- Older adults are often afraid of falling and this can contribute to them reducing their activity, which in turn makes them more vulnerable to falling.
- Although many falls may have no serious consequences they are the leading cause of mortality due to injury in people over 75.

- 20% of older adults who receive a fracture as a result of a fall will be dead within a year.

Stroke

National prevalence data indicates that:

- 4% of people or 1,124 people over 65 in Telford and Wrekin will experience a stroke
- the prevalence is slightly higher in some ethnic groups such as Afro Caribbean and South Asian men - many other factors such as lifestyle will affect prevalence.
- In March 2005 there were 2,255 people on the Telford GP Stroke Registers.

There are two main types of stroke, *ischaemic,* when a clot narrows or blocks blood vessels so blood cannot get to the brain is the most common; and *haemorrhagic* when a blood vessel bursts and leaks blood into the brain.

- Around 30% of stroke patients die in the first month
- after a year 65% of stroke survivors can live independently but 35% are significantly disabled and may need considerable support with daily living tasks, around 5% are admitted to long term residential care.

Dementia

Dementia affects 5% of people over the age of 65 and 20% of those over 80. About 700,000 people in the UK have dementia (1.2% of the population) at any one time.

The National Dementia Strategy (2009) sets out a five year transformation plan for to enable people and their family carers, to ‘Live Well’ with Dementia.

Two-thirds of all people with dementia live at home and most people want to remain in their own homes, for as along as possible. All too often, people with dementia find themselves on a ‘conveyor belt’ that takes them into long-term care residential care because it appears that there are no alternatives available – this is especially the case if the person is admitted to hospital after a crisis.

Improving services and the ability of the health and social care workforce to respond to dementia will improve quality of life by supporting independence and well-being and reduce over-reliance on services.

The financial costs of dementia are significant to the NHS, social care, families and society. In 2007, the London School of Economics estimated that the annual cost of dementia in England is £15 billion per year (more than cancer, heart disease and stroke combined). This amounts to an average of £25,000 per person with dementia per year.

In 2008, in a follow-up report, the King's Fund estimated that this cost will rise to £23 billion by 2018 unless work is done to improve the cost effectiveness of dementia services, reducing hospitalisation and use of residential care.

A key recommendation within the National Dementia Strategy includes access to intermediate care and rehabilitation, for people with Dementia. Like any other staff group, staff working in rehabilitation services need core training in dementia and access to advice and support from specialist mental health personnel.

There are currently approximately 1,489 people over the age of 65 living with Dementia in Telford & Wrekin. This is set to rise by 34% by 2019.
There is currently approximately 44 people under the age 0f 65, living with early onset dementia in Telford & Wrekin. This is set to rise by 16% increase by 2019
Pathways out of hospital, such as intermediate care exclude people with dementia because services are often reluctant to offer services for longer than 6 weeks.
There is a false assumption that people with dementia cannot benefit from rehabilitation.
Non-specialist health and social care staff have minimal or no training to understand and treat people with dementia.

Brain Injuries

Acquired brain injury (ABI) is an inclusive category that embraces acute (rapid onset) brain injury of any cause, including:

trauma – due to head injury or post-surgical damage (e.g. following tumour removal)
vascular accident (stroke or subarachnoid haemorrhage)
cerebral anoxia
other toxic or metabolic insult (e.g. hypoglycaemia)
infection (e.g. meningitis, encephalitis) or other inflammation (e.g. vasculitis).

Traumatic Brain Injury (TBI) is by far the largest ABI sub group. It is estimated that about 1 million people in Britain attend hospital each year because of head injuries.

Per 100,000 population between 10 and 15 people suffer a severe head injury, 15 to 20 people suffer a moderate head injury, and between 250 and 300 people a mild head injury. Each year around 11,600 people in Britain have a severe head injury; of these people only around 15% will return to work. Road traffic accidents account for 40% to 50% of all head injuries, and are most commonly associated with severe injuries. The largest incidence of TBI in the UK is among young adult males (mean age 25), whose injury is associated with a road traffic accident and alcohol or drugs.

People with ABI often differ from those associated with other common disabilities (eg physical disability, learning disability or mental health problems) because their problems tend to be cognitive and emotional. Most are independent before injury, most do not have persisting physical disability and the onset is sudden and not predictable. The impact of the ABI on them, their carers, families and friends is often severe and proves a challenge for carers and service providers.

Most people with ABI:

suffer from cognitive and emotional disabilities which are 'hidden' and unattributed to brain injury by the casual observer.

are in the lowest social classes and from areas with a higher social deprivation index.

do not continue in their employment

become socially isolated with friends and family not understanding or correctly attributing changes in behaviour to the ABI.

are often 'lost' to service providers after acute hospital treatment

have difficulty in coping with life events

do not access a range of proven therapies and treatments that can significantly reduce disability and can be preventative.

Multiple Sclerosis

Multiple sclerosis is the leading cause of disability in young adults. People are typically diagnosed at a median age of 30 years. Over time, MS normally becomes progressive, debilitating and causes complex disability. It is not life threatening and consequently management of MS is a long-term team effort. There are no short-term solutions.

MS is a variable condition. However, the majority of patients will develop a range of fluctuating symptoms, both physical and cognitive, which take time to assess and manage. Additionally, significant levels of coexisting conditions such as depression are found in any MS patient population. Consequently, cost-effective management of MS is time-consuming for health professionals.

The MS Service provided by Neurological Consultants and MS Specialist Nurses covers Telford & Wrekin, Shropshire and a large proportion of mid Wales. Anticipated prevalence of multiple sclerosis in the population is 100-120 cases per 100,000. In the local population the expected caseload is 500 however the actual caseload is approaching 900 with approximately 300 MS patients in Telford & Wrekin.

Incidence of new cases referred to the service is in the region of 60 per year, with approximately 50% newly diagnosed. It is anticipated that incidence of new cases will continue to rise. Mortality is 8 per year on average and at present the caseload is growing by 7% year on year

Appendix 2

Evidence of best practice

'Transforming Rehabilitation Services'

The Department of Health programme 'Transforming Community Services' aims to improve quality and productivity and ensure the best service for patients and their families. These standards have been used for this strategy as:

- They have gained support from all those who took part in developing the national guidelines as most likely to have the greatest potential to improve care and achieve the highest quality services.
- They are based on the best research evidence available.
- They have drawn on expert professional opinion and service user experience to provide robustness.

The document states that the NHS concentration on health and wellbeing (as well as treating the sick) will not happen without modern, vibrant and responsive community services delivered by highly motivated and skilled clinicians who really understand what life is like for those in their care.

More than 18,000 studies were analysed by the Health Services Management Centre (HSMC) to examine the evidence for a range of community services. The following are key recommended actions for rehabilitation services, based on evidence and professional consensus. These are for local organisations to consider when planning quality innovation and productivity improvements:

Provide rehabilitation in the community.

> There is some good evidence which suggests that rehabilitation could operate as an outpatient service in the community. Important components of community rehabilitation services include – social support, involving carers, using physiotherapy and occupational therapy, and good links between community and hospital services. However, rehabilitation services provided in the community need to be well organised, include a multidisciplinary team and use venues that are acceptable and accessible to service users and staff

Multifaceted rehabilitation works best.

> Two key messages emerge from the evidence – rehabilitation should begin as soon as possible and rehabilitation that combines many different components is likely to be most effective. The most successful rehabilitation services include personalised care plans, physical and cognitive therapies, regular practice and proactive followup.

Monitor vital signs and use alert systems.

The evidence suggests that alert systems alone are not a form of rehabilitation but that they may play an important part of a wider care package. The most common form of telemonitoring involves automated data transfer and has potential to shift care from hospital settings into the community. However, findings about the benefits of automated data transfer were not consistent. In contrast, telephone support as part of a rehabilitation care pathway has been found to improve clinical outcomes and/ or reduce symptoms.

Use self referral to services where clinically appropriate.

Self referral is a way to widen access and empower service users to seek help in a timely way as their needs change. One study found that open access used fewer acute sector resources, resulted in the same quality of life for service users and was a preferred pathway for service users and GPs. This model could potentially raise concern for demand. Another study found no increase.

Rehabilitation at home improves outcomes.

A number of studies suggest that homebased rehabilitation is just as effective in delivering improved functioning. However, it was also noted that homebased rehabilitation may place additional demands on carers and therefore consideration needs to be give to supporting carers and provision of regular respite care.

Multidisciplinary teams improve rehabilitation.

There is some evidence that multidisciplinary follow up after discharge can reduce reliance on hospital care and shift care closer to home. Several studies have suggested that there are six factors which impact on how well teams work together in healthcare:

team size
multiprofessional composition
good organisational support and equipment
regular team meetings
clear goals and objectives
regular audit and review.

Selfcare models can support rehabilitation.

Several studies suggest that helping people to take responsibility for their rehabilitation and recovery is essential. One way of achieving this is through the provision of clear information. This needs to be easily accessible, inviting and needs to encourage people to apply the skills and actions to their daily activity. Written materials to support self management can help but if used alone they may have little effect on behaviours, health outcomes or service use. Educational sessions to enable self management are also required.

Supporting carers

There is some clear evidence that supporting carers can aid a patient's recovery and rehabilitation. A UK trial recommended that carers' support should be built into the design of the rehabilitation programmes. Supporting carers is acknowledged as important but further work is required to determine the most effective methods for providing their support.

Ensure every service has a clear vision.

Some studies would suggest that a clear service vision is missing among some specific rehabilitation services. Evidence based care pathways are a tool to help provide more integrated and continuous care and to ensure that services have a shared vision.

There is inconsistent evidence that care pathways impact on clinical outcomes but some studies do suggest that simple care pathways can make a difference to people's quality of life and the care they receive are an area for further investigation.

Local ownership of services is beneficial.

Local ownership and involvement may be key to successful community based rehabilitation programmes. This may include consultation, opportunities for volunteering, recruiting local staff and enabling local community groups to make use of the premises.

Work with care homes.

The potential to work with care homes is an area that may be overlooked. They could be an alternative setting for the provision of rehabilitation services. While there is insufficient evidence that care homes either improve or reduce outcomes, one trial found significantly fewer days in hospital over the next 12 months.

Re-ablement Services

English local authorities with responsibility for adult services are increasingly developing short-term, specialist home care-based re-ablement services. Reablement can be described as an 'approach' or a 'philosophy' within home care services – one which aims to help people 'do things for themselves', rather than 'having things done for them'. Home care re-ablement services provide personal care, help with activities of daily living and other practical tasks for a time-limited period, in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves.

Home care re-ablement services can take different organisational forms. In some localities, home care re-ablement services are funded and operated jointly with NHS partners. In many local authorities, adult services departments have taken a lead themselves, often as part of the reconfiguration of the authority's home care services. Here, in-house home care staff receive training in re-ablement approaches and teams are often strengthened by the

appointment of occupational therapists (OTs), OT aides and other specialist staff. In any case, easy access to equipment by reablement team members is important.

Home care re-ablement services are normally offered for up to six weeks, with some flexibility to continue for longer if the user would benefit from this or if appropriate longer-term support services are not immediately available. Re-assessments and referrals for on-going home care and other services are made at the end of the period of re-ablement. Unlike intermediate care services, which were developed in the context of policy concerns about inappropriate hospital bed use by older people, re-ablement services are usually available to adults of all ages.

The headline findings of the study of short term outcomes and costs of re-ablement services are (take directly from 2008 publication of findings):

Impact of re-ablement on social care outcomes

> Significant short-term impact on outcomes was evident when we looked at social care outcomes for the whole cohort, both at an overall level and the individual domains.

Impact of re-ablement on dependency levels

> Changes occurring over time in the whole cohort suggest short-term improvements in activities of daily living after receiving a re-ablement service such as the ability to: get out of doors and walk down the road; wash face and hands; have a bath, shower or wash all over; get dressed and undressed; having control of the bladder

Impact of re-ablement on perceived quality of life

> Changes occurring over time in the whole cohort suggest a significant improvement in perceived quality of life after receiving re-ablement services.

Impact of re-ablement on perceived health-related quality of life

> Re-ablement service had a significant impact on health–related quality of life among the whole sample, highlighting the positive impact this service has had on the lives of service users. Post re-ablement phase, service users were reporting fewer problems with mobility, self-care, usual activities, pain/discomfort, anxiety/depression and improvements in their general health.

Impact of re-ablement on perceived health

> Changes occurring over time in the whole cohort suggest a significant short-term improvement in perceived health after receiving re-ablement services. At an individual level around a third of service users reported that their health had improved after receiving re-ablement services

In conclusion, people receiving re-ablement showed a significant short-term improvement in perceived health, quality of life and social care outcomes between the pre- and post-intervention time points. However, as the analyses in this report were not concentrating on comparing outcomes for both the re-ablement and comparison group, we cannot conclusively conclude that the changes were due to the intervention provided. The question of whether changes in outcome over time can be attributed to receiving re-ablement services will be the focus of the final report

The Care Services Efficiency Delivery Programme has also identified as good practice the routine provision of re-enablement before decisions on long term care needs are made. An initial study in 2006 showed that people who received a re-enablement service required, on average, 28% fewer domiciliary care hours than people who had not received such a service. A subsequent study, completed in November 2007, showed that the effectiveness

of re-enablement in reducing the size of care packages was sustained over a period of 2 years following re-enablement, including those for people in the 85+ age group.

In addition to the above, The National Evaluation of Services for re-ablement includes the evaluation of services aimed at prevention and early intervention. The evidence is set out in the evaluation and indicates:

Sites appear to be having a significant effect from reducing NHS hospital emergency bed use

Savings seem to be most pronounced where interventions are specifically focused on hospital avoidance

Preventative interventions and reduced demand for Local Authority funded social care support, particularly long term care placements

Some preventative work can lead to an increase in activity – particularly people who were previously unknown and a slight increase in GP appointments and contacts with practice nurses

Importantly the people receiving the service said they had benefited from re-ablement. There had been a “significant improvement in perceived quality of life” and “a significant impact on health related quality of life for the whole group”. About a third of the group reported their health had improved.

Partnership for Older People Projects

Findings from the national Partnership for Older People Projects (POPP) programme (DH 2010) provided examples of efficiency savings linked to developing more effective ways of using resources whilst also improving quality.

In contributing to the Quality, Innovation, Productivity and Prevention (QIPP) agenda, the 29 pilot sites demonstrated the importance of a preventative approach to most areas of the health and social care agenda including rehabilitation. Two thirds of the schemes were aimed at reducing social isolation and exclusion or promoting healthy living among older people. With the remainder directed specifically at avoiding hospital admission or facilitating hospital discharge.

Key outcomes related to efficiencies included:

Interventions across the POPP programme produced an average of around £1.20 saving in emergency bed days for every extra £1 spent on prevention (the range is between £0.80 and £1.60). These efficiency gains are on top of the £1 of additional service benefit from addressing older people’s presenting needs.

Higher efficiency gains are immediately available from more intensive, targeted interventions, which involve very close joint working between health and social care. (For example, proactive case co-ordination services, which actively seek out

people who may be at risk of deterioration, assess their needs and co-ordinate access.)

As well as reductions in emergency bed days, productivity gains in other areas of health service activity were also indicated. Compared with the use of services before the POPP intervention:

hospital overnight stays reduced by 47%;
accident and emergency attendances reduced by 29%;
clinic or outpatient appointments reduced by 11%; and
physiotherapy/occupational therapy appointments reduced by 8%.

The estimated efficiency gains in the health service appear to have been made without any adverse impact on the use of social care resources.

There is some evidence that improved outcomes for older people are achieved through integrated co-located health and social care teams.

University of Birmingham

The University of Birmingham researched good practice in rehabilitation services and identified 500 studies of good practice. Ten important issues were highlighted as contributing to improvements in community based rehabilitation:

1. using rehabilitation with multiple components
2. providing rehabilitation in community venues
3. testing home based rehabilitation
4. working in multidisciplinary teams
5. encouraging self referral to services when needed
6. teaching people to care for themselves
7. providing extra support for carers
8. working with care homes
9. ensuring community ‘ownership’ of services
10. using alert systems and other monitoring

Their research showed that specific studied were able to demonstrate savings:

Using alert systems and other monitoring

A case control study in the UK found that a home alert system for people with dementia may help people stay at home and have improved functional status. Another observational study in Scotland compared the costs of a home alert system and call centre for 170 people staying in their homes versus 170 care home places. The estimated cost saving was £1,689,970. Alert systems alone are not a form of rehabilitation but they may be an important part of a wider care package. Locally there are examples of case studies in Telford & Wrekin where evaluation of the use of bed occupancy sensors have

demonstrated significant potential for savings associated with falls prevention, a move to a care home setting and costs assocaited with repsite provision.

Testing home based rehabilitation

A number of studies have emphasised the value of providing rehabilitation and other services at home. Studies in Denmark and Sweden found that moving people out of institutional care and into the home, supported by home based rehabilitation and housing adaptations, could be less costly, improve patient satisfaction and increase independence. Another study found that elderly people receiving long term care at home fared better than those in hospital. Those at home had better quality of life with no evidence of greater stress upon their carers. There were increased costs for social services, but as a whole healthcare costs and costs to society were lower than the long stay hospital option. Case management and generic rehabilitation were integral to this approach.

Teaching people to care for themselves

Educational sessions to help people learn about how to undertake activities or manage their condition more effectively have gained increasing popularity in recent years. For instance, a randomised trial in six US hospitals examined self management rehabilitation education for older women with heart disease. Days in hospital reduced by 46% and inpatient costs were 49% lower than usual care. Hospital cost savings exceeded the cost of self-management education by 5 to 1.

Health Service Management Centre

In 2006, the Health Service Management Centre (Birmingham University) and the Strategic Health Authority published a report entitled: 'Reducing unplanned hospital admissions. They searched 17 literature databases and contacted experts in the field. In total, they assessed 65,812 studies of which 186 met the criteria for the review.

In summary, they state there is some evidence to suggest that the following initiatives may reduce unplanned hospitalisations and readmissions:

- self-management education,
- self-monitoring,
- group visits to primary care,
- broad managed care programmes,
- integrating social and health care,
- multidisciplinary teams in hospital,
- discharge planning,
- multidisciplinary teams after discharge,

- care from specialist nurses,
- nurse-led clinics,
- telecare,
- telemonitoring.

There is some evidence that the following may reduce length of stay in hospital:

- self-management education,
- telecare,
- multidisciplinary teams in hospital,
- discharge planning,
- home hospitalisation,
- educating professionals.

These interventions may reduce length of subsequent hospital stays:

- targeting people at high risk,
- self-management education,
- telemonitoring,
- multidisciplinary teams in hospital,
- multidisciplinary teams after discharge,
- nurse-led clinics and nurse-led follow-up,
- assertive case management,
- home visits.

The report concludes that given the paucity of high quality evidence about which interventions reduce unscheduled admissions most effectively, it is important that organisations implement a strategy to evaluate all current and future initiatives fully.