King's Fund Programme:
Developing Rehabilitation Opportunities for Older People

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Rehabilitation in rapid response services: maximising opportunities for older people

This report captures the reflections of people working in and managing rapid response services

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Contents

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Key Messages

Factors influencing the development of rapid response services

- A range of rapid response services have been set up which aim to provide a swift response to people's identified health and social care needs in their own homes. This can prevent inappropriate hospital admission or facilitate early discharge.

- Many factors are converging to generate a high interest in rapid response services, including:
  - pressures on hospital beds
  - inappropriate admissions to residential and nursing homes
  - rising costs of long-term care
  - a recognition of the benefits of providing a range of services to meet the rehabilitation needs of older people
  - a clear policy direction from the government towards the development of intermediate care as part of the NHS Plan.

- Developing rapid response services can involve an enormous change in established working relationships, practices and organisational culture. It is important that this is recognised. Change management skills can greatly assist the process.

- Projects need backing from senior management, who share the agreed vision for developing older peoples services, and can identify the resources necessary to progress the work to mainstream provision.

- Some services struggle to secure a range of expertise to provide an efficient and effective service to users and carers.

- Many services have developed quickly, as a result of short-term funding and/or in parallel to other services. In some areas there is an urgent need to consider how the service fits within wider health and social care provision. This is critical both for the provision of integrated services and to ensure equity of access.

- There is scope for further development of existing models of service, e.g. the potential role of extra-care sheltered housing and the development of admission criteria to include other vulnerable groups, such as people with dementia.

- The organisational characteristics that make stroke care effective may also be appropriately applied to understanding the efficacy of rehabilitation in other situations, particularly where several disciplines have a distinctive and complementary role to play and where the co-ordination of a range of inputs is required.

- Where charges are levied to pay for the social care element of the service it is important that the amount set does not stop users from accepting the service.

Operational Issues

- Rapid response services have been developed in a number of ways. This is reflected in the various titles given to the models of services that have emerged. Titles of services do not always capture the full range of the service provided. It is therefore important that the team clearly communicates its purpose to stakeholders, users and carers.

- Rapid response services usually encompass health and social care needs. Issues can arise about 'medical' and 'social' models of care, which need to be resolved.

- Comprehensive assessment is critical if older people are to be referred for care in the most appropriate setting to meet their needs. It is important that the assessment process includes an assessment for rehabilitation potential and that thereafter rehabilitation is available to people who will benefit.

- Protocols can help to ensure that best practice is followed, and that the transfer of care between sites and organisations is smooth.

- A strong feature of rapid response services is the development of new roles and responsibilities among a range of professional and non-professional staff, from both health and social care. Understanding different roles and responsibilities is important, particularly as professional boundaries blur and team members take on additional responsibilities.

- Good communication is important on a number of levels:
  - professionals, users and carers need to know about the service
  - information must move with the user
  - staff need to be informed about how to access resources easily
  - access routes into the service and for referring on must be clear.

- Cross skilling is important, providing adequate training, professional support and line management is in place.

- New types of support workers have a role in most teams. These non-professionally qualified assistants and helpers are an important resource that can be used, with appropriate training and supervision, to help teams meet rehabilitation goals.

- Services take time to develop and become established, particularly when staff are required to work in different ways. If new services are developed without adequate planning, preparation and time to 'bed in' there is a risk that they will fail.

- Evaluating and monitoring the service at an early stage can be an important driver for developing the service and securing future funding. It can be approached in a number of ways.

Section One: Introduction

Rapid response is an important concept in health and social care terms. It meets one of the key principles that underpin the provision of care to vulnerable and sick people, i.e. that services should be timely in responding to people's needs.

This report has been prepared to share information about rapid response services for older people, to encourage the identification and adoption of good practice and to give people the opportunity to learn from the experiences of others.

Definitions of rapid response service vary because of the variety of ways in which services have been set up. In its broadest sense it is a model that aims to respond within hours of referral to people's identified health or social care needs. This is often at a time of crisis, when arrangements are swiftly made to provide care and support for a defined period of time, usually in a person's home. The service usually aims to prevent inappropriate hospital admission or facilitate early discharge.

The report draws heavily on information shared at a workshop held by the Rehabilitation Programme Team at the King's Fund on 7 February 2000, as well as drawing on relevant information from the literature. Participants were invited to attend because of their experience and expertise gained through setting up and running a variety of services that come under the rapid response umbrella.

The focus of the workshop was on teasing out those aspects of service planning and organisation that are important if service users are to be offered rehabilitation. This focus was chosen, as experience to date shows that there is a danger that short-term interventions can miss rehabilitation potential, unless rehabilitation is firmly on the service agenda. The report contains:

- a brief statement of where rapid response fits in the government's policy agenda
- key themes/issues that emerged from workshop discussions
- some useful references
- details of specific services, encompassing a range of service models, in the form of the overheads from presentations by service providers at the workshop

1.1 Rapid response services in context

Through the King's Fund Rehabilitation Development Network we have seen the development of a number of service models designed to respond quickly to meeting the needs of older people.

Interest in rapid response was further stimulated when the government issued the NHS High Level Performance Indicators (HSC 1999/139) and the Social Services Performance Assessment Framework (LAC(99)27), the findings of the National Beds Inquiry were published (DoH, 2000) and most recently the NHS Plan (DoH, 2000).

The government has made it clear that it expects to see the development of models of care that recognise people's potential for recovery and which provide care at, or close to, people's homes. A clear link has been made between rehabilitation and recovery, the effective management of acute hospital beds and the avoidance of inappropriate admissions to long stay care.

The aims then are clear – to provide a swift response to people's health and social care needs and at the same time to address a number of recognised pressure points in the health and social care service systems.

It is perfectly possible to address service pressures without addressing a client's potential for recovery/improvement and his or her need for rehabilitation. For example, intensive nursing services may keep an acutely ill person at home, but this may result in the patient losing their ability to look after him or herself in the longer term, unless staff take on an enabling role. It is therefore important to ensure that the assessment process includes an assessment for rehabilitation potential and that thereafter rehabilitation is available to people who will benefit.

There are, however, a number of ways in which rapid response has been developed. This is reflected in the various titles given to the models of services that have emerged. In many areas services have developed in part or full rapid response provision but the name of the service does not overtly reflect this. This is evident from the titles of the teams that participated in the workshop:

- rapid response
- crisis care
- early supported discharge
- community rehabilitation teams
- community rehabilitation services
- generic community services
- hospital at home

Despite the differences in title, the typical rapid response service aims to put appropriate support in place within hours of a referral from a GP/hospital/social worker. Support is provided in people's homes for a short period of time. The service typically supports older people whose health and/or social care needs puts them at risk of admission to hospital, as well as those who present at hospital and who could more appropriately be cared for at home, providing services are put in place promptly. Typically this encompasses health, social and rehabilitative support, provides prompt access to equipment, and facilitates referral to other forms of support.

Even so, within and between these services there are notable variations in staffing levels, skills mix, operational and organisational arrangements such as admission criteria, length of stay, and location of staff.

It is these differences that the workshop set out to explore.

1.2 The Workshop

The aim of the day was to hear about a variety of service models and to try to get a consensus on:

- how an ideal service would look
- what key components are needed in rapid response services to enable the rehabilitation needs of older people to be met.

While rapid response services have developed in different ways, and with different priorities, workshop participants found that many of the issues that were important to their services were common to them all. Many come as no surprise. However they were raised as issues that needed to be considered or resolved if rapid response services are to be developed to meet the needs of older people. Where opinions varied the report aims to capture these differences to enable readers to make their own judgement.

Section Two: Aims of the Service

The reasons why rapid response services have developed in many different guises were clear to participants. In most cases the initiatives have been about providing local solutions to the pressures that exist in the local health and social care system, such as pressures on acute beds or specific gaps in community service provision. These have led to service responses that aim to:

- promote early discharge from hospital
- avoid unnecessary admission to hospital
- avoid unnecessary admission to long-stay care.

Some services aim to do all three and therefore accept a wide range of referrals. Others focus on either acute referrals or referrals from the community, although it is not uncommon for a service that has been set up to address only one service pressure, such as promoting early discharge from hospital, to move on to develop and accept community referrals.

2.1 Shared philosophy

A shared philosophy, sometimes referred to as the 'values' or 'principles', was identified as essential in order to develop the service. This needs to be closely linked to the aims of the service. Not surprisingly, the components identified are common to other models of care. Those highlighted were that the service needs to:

- be user-focused
- provide timely rehabilitation
- enable a flexible approach that challenges traditional approaches to providing support for older people
- prioritise the development of good communication methods
- have education and learning at its centre
- be clear about what can and cannot be provided
- be clear about how safety and risk will be managed.

Not surprisingly, the importance of involving all the key agencies and stakeholders was emphasised along with the need to secure senior management commitment.

The importance of ensuring that the aims and objectives of the service are aligned across organisational boundaries was also highlighted.

A 'champion in a high place' was identified by some participants as important, as well as strong leadership. Embedding the aims of the service in the wider political context and the local strategy for older people was seen as particularly important if projects were to become part of mainstream provision.

On the whole it was felt that the desire of many patients/users to be cared for in their own home fitted well with national policy, such as the drive to reduce inappropriate hospital admissions, Best Value, the National Beds Inquiry and most recently the NHS Plan.

2.2 Evaluation and monitoring

The importance of evaluating and monitoring the service at an early stage was identified as paramount. Doing this has helped those involved to:

- understand key process issues
- assist with further development
- have a greater understanding of costs and effectiveness.

It has been approached in different ways. Some teams have found external evaluation by a recognised research body an important driver to obtain long-term funding: others have found a well-planned local evaluation effective, particularly as staff must be involved.

Section Three: Developing the Service

3.1 Strategic planning

Deciding on the scope of the service is important and will have implications for future developments, particularly around the integration of services.

A number of workshop participants described their service as developing with incremental 'add-ons' such as 'hospital at home'. In many cases these were seen as appropriate, but there was also a concern that this was often driven by other pressures, e.g. the availability of funding and pressures on acute services. A concern voiced was that this 'opportunistic' approach often lacked strategic direction.

This starts to raise some key questions for services that are 'starting from scratch', such as:

- what needs to be included from the start
- who should provide the service
- how it will integrate with other services
- whether the service should be piloted initially or be part of mainstream services.

Opinions of participants differed. Some felt that it was important not to be too ambitious at the beginning, and that services should be started as small-scale pilots: others felt that a strategic approach was paramount from the start. This is a critical issue that has important operational and strategic implications.

In 1998, when the King's Fund and Audit Commission jointly commissioned two literature reviews on rehabilitation, a key finding of the reviews was that in order to make progress for users and carers, a strategic approach was essential (Robinson & Turnock, 1998). However there is much anecdotal evidence that the complexity of the issues have made the realisation of a strategic approach extremely difficult. Problems identified include:

- short-term funding
- inflexible mainstream budgets
- difficulties moving money around the system – particularly moving money from the acute sector to the community
- difficulties changing mainstream working practices.

Where progress has been made, short term funding has often provided the opportunity to explore different ways of working.

Participants emphasised the importance of linking the objectives of the service, whether it was part of mainstream care or a pilot on short-term funding, to both local and national priorities and ensuring that it is embedded in local strategic plans. The need to consider how the service fits within wider health and social care provision was also highlighted as critical if an integrated service is to be provided for users and carers. This is also important to ensure older people can access the service equitably.

3.2 Funding

Many services were initially set up as winter pressure initiatives, often under joint finance arrangements. On the one hand, this has provided a 'window of opportunity' to develop a new type of service: on the other, the nature of this type of short-term funding has had organisational implications, for example on the recruitment and development of staff and the development of inter-agency working relationships. Not surprisingly, mainstream funding was seen as critical for future developments. The new partnership flexibilities (DoH, 2000), introducing pooled budgets and integrated service arrangements, were seen to have the potential to address some of these issues.

3.3 Getting started

Time for development is critical to ensure that:

- the support of stakeholders is gained
- the service is publicised
- new working practices are developed and agreed
- staff have time to team build.

Experiences shared at the workshop, as well as elsewhere in the literature, suggest that recruiting new teams to operate in completely new ways requires at least six months planning and preparation and considerably more time to 'bed in' (Herbert, 1998).

3.4 Communicating the existence of the service

To ensure that rapid response services are used appropriately it is extremely important that the purpose of the service is clearly communicated to potential referrers and users.

Experiences from participants and elsewhere (Vaughan *et al.*, 1999a) indicate that this includes:

- the purpose and scope of the service
- who may benefit
- the referral process
- how it can be accessed
- how it will impact on different parts of the system, e.g. primary care.

This will need to be communicated to a whole range of people and organisations, depending on the service and the local context. Evidence from a review of community rehabilitation services in North Yorkshire shows that many people who could benefit are not referred because referrers are not made aware of the new service (Herbert, 1998).

Key people and organisations that need to be informed include:

- potential users of the service and their carers
- acute care services (including medical staff, bed managers, therapists, nurses, social workers, clerical staff)
- primary care teams, groups and trusts
- community trusts and hospitals
- social services
- health authorities
- housing services
- aids and adaptation services
- voluntary organisations
- ambulance services/hospital transport.

In some areas where rapid response forms part of a range of services with common aims (e.g. residential rehabilitation, day rehabilitation), teams have found it helpful to have an umbrella name for the service that is easily recognised by professionals, users and carers. Rotherham's Community Assessment Rehabilitation and Treatment Scheme, known as CARATS, is an example of this (Sanderson & Wright, 1999).

3.5 Establishing and maintaining trust and understanding

As well as informing stakeholders of the existence of the service, convincing them of its merit also requires careful consideration and planning. The need to 'sell' the service to whole range of stakeholders as early as possible is important. This needs to be an ongoing process. In areas where there is a high staff turnover this becomes particularly important. Participants spoke of the need to 'trawl

A&E Departments for referrals' and to 'work intensively with general practitioners to convince them that the service would work'.

The message was clear that considerable work is needed not only to build up trust and confidence but also to maintain it. Two examples of methods used are:

- rotating inpatient staff on to the rapid response service to increase their understanding of the capacity of the team to care for patients who traditionally would have been cared for in the acute sector
- using liaison roles to "build a bridge" between primary and secondary care.

3.6 Team building

Good team working was identified as being at the heart of rapid response services. The need to generate trust and understanding *within* the team is paramount. Participants spoke of the importance of building a genuine team culture of openness and mutual learning. This takes time to develop and needs to be continually worked at. Understanding the roles and responsibilities of other team members is critical to success, particularly as professional boundaries blur and team members take on additional responsibility. Participants felt strongly that staff need time to develop the trust needed to work in new ways.

Regular team meetings were identified as critical both to enable effective communication and to support staff as roles developed and changed. Making sure that the meetings worked for the team was seen as important. Some teams found daily meetings effective, others met less frequently.

3.7 Co-located teams or attached generic services?

Across the country there are examples of rapid response services that are provided through teams specifically recruited for the service and others that are organised around generic services such as district nursing and community occupational therapists. Some teams are co-located and others are attached.

Opinions were divided as to the 'ideal' organisational structure of staff:

- co-located teams felt strongly that this enables effective communication, which leads to a more integrated service
- attached generic services felt that they are more able to integrate with mainstream services.

Whether one model is more able to meet the needs of users is difficult to determine. What is clear is that good organisation is essential to maximise the effectiveness of rehabilitation. This is reinforced in the Audit Commission's

recent publication on rehabilitation which states that 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' (Audit Commission, 2000).

The evidence to support this is strongest for stroke care but has wider applicability (Sinclair & Dickinson, 1998). The important characteristics of stroke units are:

- co-ordinated inter-disciplinary care
- involvement of family and carers
- staff specialisation in stroke or rehabilitation
- education of staff, users and carers.

The evidence for this is strong and is not restricted to sub-groups of patients or model of stroke unit. People 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 people in non-specialist wards and units (Stroke Unit Trialists' Collaboration, 1977).

The characteristics that make stroke care effective may also be appropriately applied to understanding the efficacy of rehabilitation in other situations, particularly where several disciplines have a distinctive and complementary role to play and where the co-ordination of range of inputs is required. It is recommended that the evidence (together with that for assessment) should 'be translated into routine practice and used to inform rehabilitation developments for other conditions' (Sinclair & Dickinson, 1998; Audit Commission, 2000).

It is also important, particularly for those 'starting from scratch', to consider how pilots will be rolled out in the future. Examples were given where resources were available at the pilot stage that could not subsequently be delivered as part of mainstream services.

3.8 Timely rehabilitation

Providing timely rehabilitation is critical to meeting the rehabilitation needs of older people. This appears to be most effective where the team has appropriate skills or resources within its service, or where clear and simple access routes have been identified elsewhere.

Participants felt that for the service to respond appropriately to the needs of older people, the service needed to be seven days a week, with clear access to

the range of skills that the team had, including medical support. A number of factors were identified that enabled a timely response:

- clear and simple referral processes, e.g. one point of referral
- a rapid assessment system
- appropriate transport facilities
- access to equipment and quick adaptations – described by a number of participants as a 'man with the van', who could access equipment and ensure that it is repaired and returned to the system
- flexible staff with core skills
- flexible working patterns – particularly around staff hours, to enable the service to respond to the 'peaks and troughs' in demand
- good communication.

3.9 Bridging the gap

Participants spoke of their role in bridging the gap until social services packages are put in place. In some areas, teams experience difficulties in working with different social services departments. Participants working in London spoke of the frustration of being able to work more effectively in one geographical area than another because of the different policies and procedures of social service departments. For example some teams had a care manager for only part of the geographical area that they covered.

Section Four: Comprehensive Assessment

The importance of good assessment was identified as a key issue if older people are to be referred for care in the most appropriate setting to meet their needs.

This is supported by strong research evidence which has shown that comprehensive assessment, when followed by the implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in care homes (Sinclair & Dickinson, 1998). It also improves people's physical and cognitive function and reduces death rates by 35 per cent. Effects of this magnitude are greater than those seen for many accepted drug treatments (Sinclair & Dickinson, 1998; Audit Commission, 2000).

Participants felt that assessment should be seen as continuous, rather than the end point of the referral process and be linked to care planning and goal setting. It was also felt that the process should be client led, rather than professionally led and that a common tool should be used and shared.

One perspective aired at the workshop was that expert medical assessment should be pivotal. Opinions on this varied. On the one hand there was agreement that good medical assessment should be available if required quickly. This was set against the view that it was not necessary for medical assessment to be pivotal but rather that it should be one of a number of possible contributions. A concern voiced was that nurses and therapists may not have the diagnostic skills to identify potential or actual physiological problems at an early enough stage.

In practice these concerns do not appear to be well founded. Reports from intermediate care schemes suggest that when older people become unwell it is most commonly because a further acute incident has occurred, which would have been the case in whatever setting they were offered care (Vaughan *et al.*, 1999a). What appears to be critical is that there is a clear pathway to medical assessment *when it is needed.*

4.1 Shared records

Shared records to which all team members contribute and are held by the patient/user as he or she moves through the system, was seen as a key to effective communication.

There was also some optimism about the future role of information technology.

4.2 Protocols and guidelines

Protocols and guidelines were used by many of the teams. This was seen as particularly important when team members were making decisions that are traditionally beyond their scope of practice. It is interesting that the well reported argument about guidelines and protocols 'stifling' professional judgement were not voiced.

4.3 Goal setting

The majority of participants identified goal setting as underpinning their work. There was common agreement that goals should be client led and that they should follow comprehensive assessment.

Goals are defined here as aims that reflect the needs identified by clients/carers and that are agreed by the professional staff as being achievable.

Participants spoke of particular difficulties setting goals given that their interventions were time limited (some only 48 hours). It was suggested that it is important to recognise these difficulties especially in the short term when it is difficult to predict the future. There was agreement that goals will be set that change as the needs of the older person change and develop.

In practice tensions existed between professionally-led and client-led goals and multi- and intra-disciplinary goals. It was felt that it is important to acknowledge this openly if progress is to be made. Despite this, most teams at the workshop valued the goal setting approach to the extent that they would find it difficult to go back to a professionally-led, service-centred approach.

4.4 Referring on

Lengths of service provided vary, with some as short as 48 hours. This means that the pathway of care often involves a transfer between both sites and organisations. It is therefore essential that people are referred to an appropriate pathway of care when discharged from the service. Continuity of care is dependant on both:

- the availability of appropriate services
- appropriate access and referral.

These are critical if the rehabilitation process is to be followed through and people are referred to the most appropriate setting to meet their needs. Clear protocols to ensure that the transfer of care is smooth were identified as desirable.

Section Five: The Shape of the Team

A strong feature of these services is the way in which new roles and responsibilities have developed. This has occurred in a number of ways:

5.1 Cross skilling

Participants highlighted cross skilling as an essential component of rapid response services. This was seen as particularly important if older people were not to be inundated by numerous different staff. It is perhaps surprising, given previous resistance to these developments – voiced as concerns about the potential to lose the uniqueness of each professional role – that participants were so positive about the importance of cross skilling. The message was clear: cross skilling is essential, as long as adequate training, professional support and line management are in place.

5.2 Shifts in responsibility

Shifts in responsibility are occurring in two areas:

- between sectors
- between occupational groups

Given that rapid response services aim to prevent inappropriate admission to or facilitate early discharge from hospital, many older people are being cared for in their own homes when previously they would have been cared for in hospitals.

In some rapid response services, the acute care medical team retains clinical responsibility for patients/users being cared for at home. Direct care givers (usually either community nurses or staff employed by the acute trust to work across the hospital/community interface) are given authority to contact the medical team for advice or given direct access back to the acute sector for assessment, treatment and re-admission if necessary.

In practice, referral back to the acute trust appears to be rarely used, but nonetheless it is considered useful particularly at the early stages as GPs become accustomed to the service and their developing role.

In some areas these new roles continue to challenge established ways of working. This takes time to resolve. Participants spoke of the need to address this through training and development programmes for all staff.

5.3 Generic workers and rehabilitation assistants

Essential to the success of many teams has been the development of new types of support workers with a more generic role. These 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 do not replace professional time, but help to maximise their time.

These roles come in many guises. Examples include:

- rehabilitation assistants
- rehabilitation care assistants
- generic workers
- support workers

At the heart of these new roles, if the rehabilitation needs of older people are to be met, is an overall approach which 'enables' people rather than 'doing things for' people. Many teams have trained assistants to carry out routine tasks and practice sessions, thus increasing the overall input, on top of the amount delivered by qualified staff.

Clear job descriptions, adequate supervision and ideally written protocols to guide assistant contributions are important (Audit Commission, 2000).

Frustrations were voiced about the lack of nationally recognised training qualifications for these new roles. Training programmes have been developed by some trusts and social services training departments to reflect these changes.

Section Six: Threats to Success

Participants identified a number of potential threats to the development of the service. Many relate to the boundaries that rapid response services cross.

6.1 No shared language

A number of participants spoke about the lack of a common language among staff coming from different professional and organisational backgrounds. In practice when teams have had time to develop a shared language, great progress has been made. However, it was stressed again that this requires good management and time to achieve.

6.2 Charging issues

There are many different approaches to charging users for the personal care element of rapid response services. This is because charges for social services are set locally.

In some areas charges are waived during the rapid response intervention. In others, it was reported that charges are set so high for the social care elements of the service that users often refuse to accept the service. Findings from a recent review of rehabilitation services by the Audit Commission support this, suggesting, in light of such examples, the issue of charging needs to be reviewed if such schemes are to develop and play as effective a role as they could (Audit Commission, 2000).

It is also worth noting that in some areas health services staff, particularly in the acute sector, do not refer people to the service because of their concerns about the cost of the means-tested social care element (Sanderson & Wright, 1999).

6.3 Managing change

The problems and issues relating to change management were openly acknowledged by participants. Clearly not everyone will welcome the challenge of working in different ways. Through the workshop we have seen that these changes can be achieved. If the challenges ahead are acknowledged at the outset, and if change management skills and techniques are employed, then there is a greater chance the service will develop successfully.

Section Seven: New Developments

Examples were given of new developments that were planned or that had been developed:

7.1 Changing admission criteria

A number of services were exploring the possibility of developing their role to include older people with different needs, e.g:

- care in dementia
- palliative care

This is encouraging as it has been a common pattern across the country for these groups to be excluded.

7.2 Role of the local authority and the voluntary sector

In most parts of the country, with some exceptions (Paterson & Desoer-Forster 1998; Bond, 1999) the role of the wider local authority, particularly housing, is yet to be fully explored. This was recognised at the workshop as a significant opportunity, particularly to meet the needs of very frail older people. Some teams are beginning to develop the role of extra-care sheltered housing with both local authority housing and the voluntary sector.

7.3 Home economist

Other services included interesting roles such as a home economist to provide advice and support on issues such as diet, cooking and managing household bills.

Conclusions

Participants spoke of the many challenges that they had faced as they developed rapid response services to meet the needs of older people. They were extremely positive about the benefits of their services to users and carers. The development of creative relationships across a range of agencies and professions enable a more flexible approach to be adopted to meet the needs of users and carers. Solutions were thus being found to tackle old problems.

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COLLABORATIVE CARE TEAM
CMH & PARKSIDE
80% 20%

Presenter: ANGELA GODDARD
Team Manager

MULTI-DISCIPLINARY TEAM

NURSES - G & F Grades
PHYSIOTHERAPISTS - Senior I & 11
OCCUPATIONAL THERAPIST - Senior I
HEALTH CARE ASSISTANTS
CARE MANAGER
'MAN with a VAN'
With access to:-

COMMUNITY Speech and Language Therapist
Dietitian
Chiropodist

WHAT THE COLLABORATIVE CARE TEAM DO?

- Acute Hospital at Home care
- Rehabilitation
- Bridging and Social Care

CASE LOAD

- Surgical
- Orthopaedic
- Respiratory
- Rehabilitation
- Elderly
- IV Drugs
- INR
- Social 'bridging'

REHABILITATION

- A&E - mobility problems
- Respiratory - COPD,bronchiectasis etc.
- Rehab with short term social care
- Care of the Elderly
- Neurological

NEURO REHABILITATION - CRITERIA

- Patient medically stable
- Patient orientated & compliant with care
- Patient's home safe or able to be made safe
- Patient must be continent at night or able to transfer onto commode
- Swallowing status must be stable, with ongoing monitoring from SALT
- Patient can transfer with one or independently if lives alone

ASSESSMENT

- Patient assessed on medical ward following admission
- Discharge plan started when patient is medically stable
- Barthel, FIM,Mini mental test, Goal setting, Outcomes monitored
- Patient taken on protocol - standard pathway of care / milestones / variances.

LENGTH of TREATMENT

- Patient offered 6 - 8 weeks with CCT
- Referred to the Elderly Community Team for ongoing rehab. If over 65.
- If under 65, or from out of area, other referral providers are sought
- Have kept patients for three months if no other service available

DEVELOPMENTS

- COPD
  - Pilot 6 months - discharge 3 days post admissions
  - Respiratory specialist physiotherapist seconded to team
  - some elderly & A&E referrals in addition to project

Developments - cont.

- Care Manager - partnership moneys from one health authority / council
  - – - joint training
    - » - assesses discharges with under 3 days notice
    - » - Support worker & secretarial time
    - » - Rehab. component

Developments - cont.

- Stroke rehabilitation protocol - developed by all staff & piloted on ward
- Inpatient staff rotating with CCT
- Interface staff

PROBLEMS

- Finding patients on acute wards
- Team speed v. in patient staff in assessing/acting
- Possession !
- Trust !

ACUTE CARE AT HOME

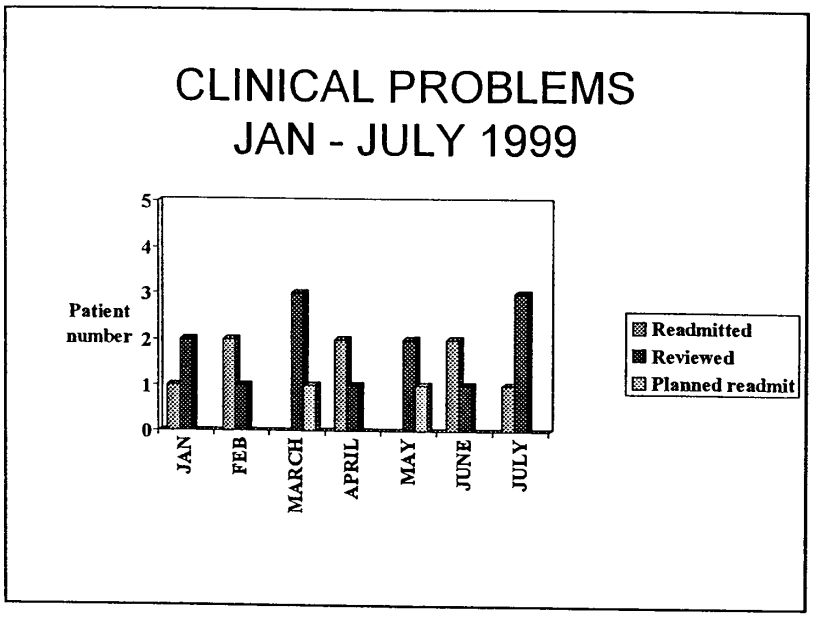
Advantages:-

Patients prefer to be at home.

- Functional rehab.relating to the patient's own surroundings
- Patient's confidence and independence level improves.
- Patients feel safe with a professional team giving structured care.
- Studies have shown patients recover well at home - especially Neurological patients.
- Eases Waiting List problems.
- Prevents hospital-based infections.

STRENGTHS

- Acute Care covered by appropriate medical team
- Specialist professional skills within team
- Cross skilled to maximise quality of care & resources available
- Level of skills constantly reviewed & updated


CLINICAL PROBLEMS
JAN - JULY 1999
Patient number
0
1
2
3
4
5
JAN
FEB
MARCH
APRIL
MAY
JUNE
JULY
Readmitted
Reviewed
Planned readmit

Maureen Rae
Princess Royal Hospital

MID SUSSEX NHS TRUST

INTENSIVE HOME
NURSING SERVICE

Mid Sussex NHS TRUST

AIM

- To provide a hospital level of nursing care within a patient's home

Mid Sussex NHS TRUST

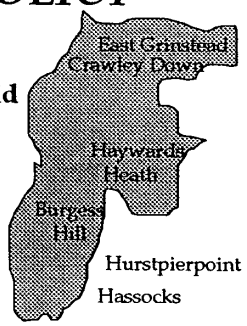
ACCESS TO SERVICE

- admission from community via GP or district nurse
- admission from hospital via liaison sister

Mid Sussex NHS TRUST

OPERATIONAL POLICY

- available to all patients living within Mid Sussex District Council Area
- operates 365 days a year
- 24 hour on call system
- length of stay on IHNS usually no longer than 14 days



Mid Sussex NHS TRUST

STAFF

- Team of qualified and unqualified nurses - 15
- Physiotherapists - 2
- Occupational therapist - 1
- Administrator - 1

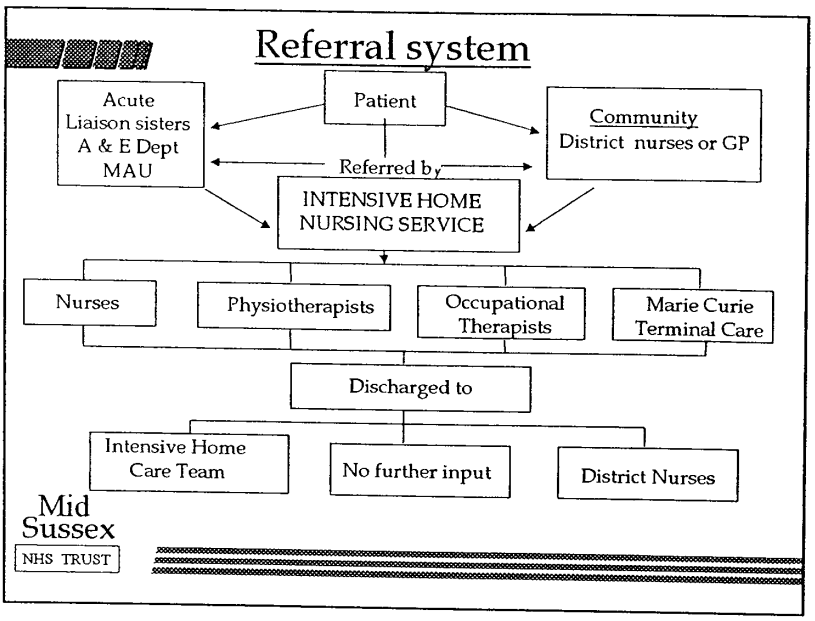
Mid Sussex NHS TRUST

TYPES OF CONDITIONS

- surgical
- medical
- orthopaedic
- elderly
- chronically disabled - acute phase

- exclusions - midwifery and mental health

Mid Sussex NHS TRUST



PATIENT MONITORING/ DEVELOPMENT WORK

- **Integrated Care Pathways**
- **Joint agency working - IHCT/Generic Carer Scheme**
- **Patient statistics/referral patterns**
- **Audit/clinical effectiveness**
- **Standard setting**

Mid
Sussex
NHS TRUST

KEYS TO SUCCESS

- **Flexibility - core staff, bank staff**
- **IHNS equipment store**
- **Ability to admit at short notice**
  - **Referrals taken up to 10.00 pm**
  - **24 hours on call for patients on service**

Combined Acute/Community Trust

- **Responsive to changes affecting both areas**
- **Ability to rise to new challenges**

Mid Sussex
NHS TRUST

Day Medicine Care & Rehabilitation

Dr Peter Kroker
Professor Brian Livesley

Chelsea & Westminster Hospital
Imperial College School of Medicine

The scope of the Problem

1991: 9 million UK citizens > 65 years (15.6%)
2 million > 80 years (3.6%)

2020: 12 million UK citizens > 65 years (20.4%)
3.5 million > 80 years (5.9%)

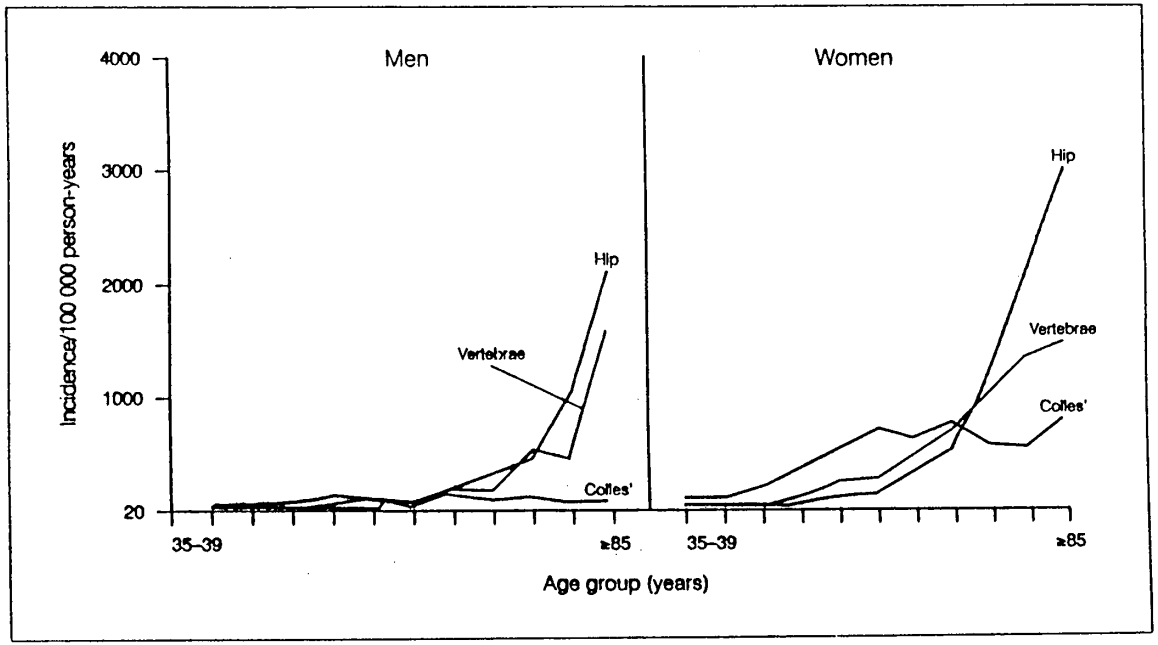


Figure 1.2 Age-specific incidence rates for hip, vertebral, and distal forearm fractures in men and women. Data derived from the population of Rochester, MN, USA.

Data from: Cooper et al [3].

Costs of hip fracture management

- In-hospital episode ~ £5000 per case
  (or about £300 million in 1997)

- Follow-on costs for 1st year £10,000 - £15,000
  (for 1997; £600-900 million)
  source: Am J Med 1997, 103, 205-255)

N.B. The yearly costs of hip fracture in the UK is probably around £1 billion

Years of Remaining Life at Beginning Age

	Males		Females	
AGE	**White**	**Black**	**White**	**Black**
65	**14.2**	**12.9**	**18.5**	**16.5**
70	**11.3**	**10.5**	**14.8**	**13.4**
75	**8.8**	**8.3**	**11.5**	**10.7**
80	**6.7**	**6.3**	**8.6**	**8.2**
85+	**5.0**	**4.5**	**6.3**	**6.1**

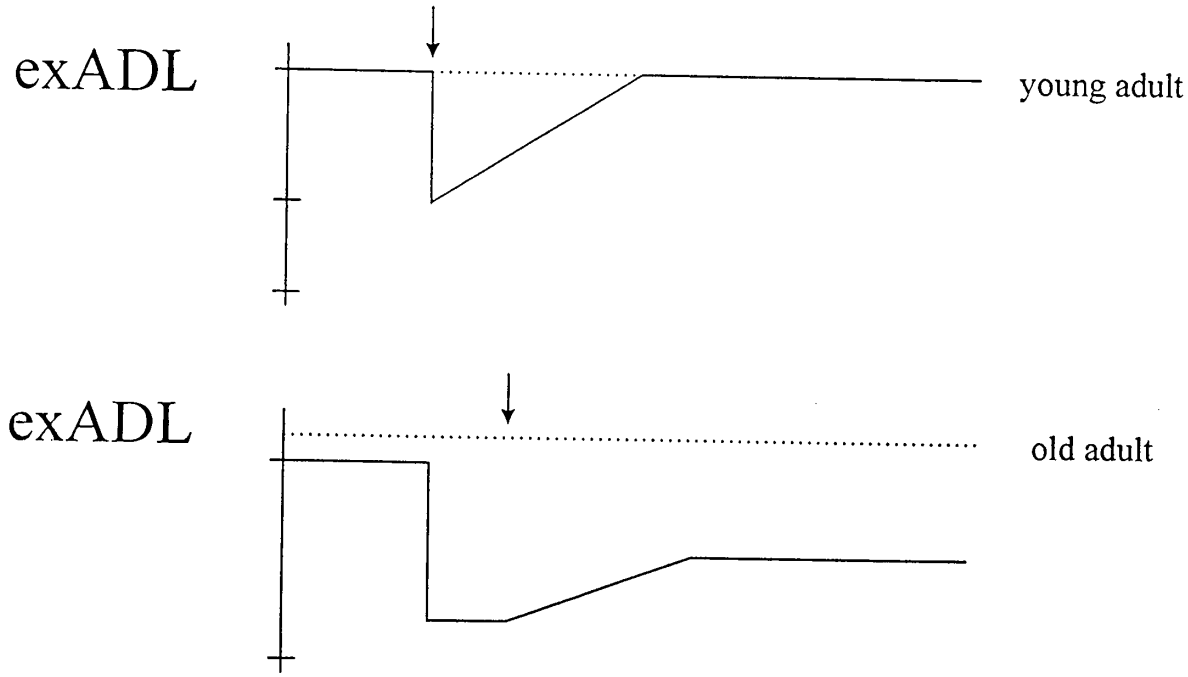
Vital Statistics of the US: 1980 Life Tables, Vol. 11, Sec 6, DHHS Publication No (PHS) 84-1104. Washington, DC: US Government Printing Office 1984

Definition of rehabilitation

- the restoration of normal form and function after illness or injury
- the restoration of the ill or injured patient to optimal functional level in all areas of activity

Dorland's Medical Dictionary (1995)

Rehabilitation in elderly people



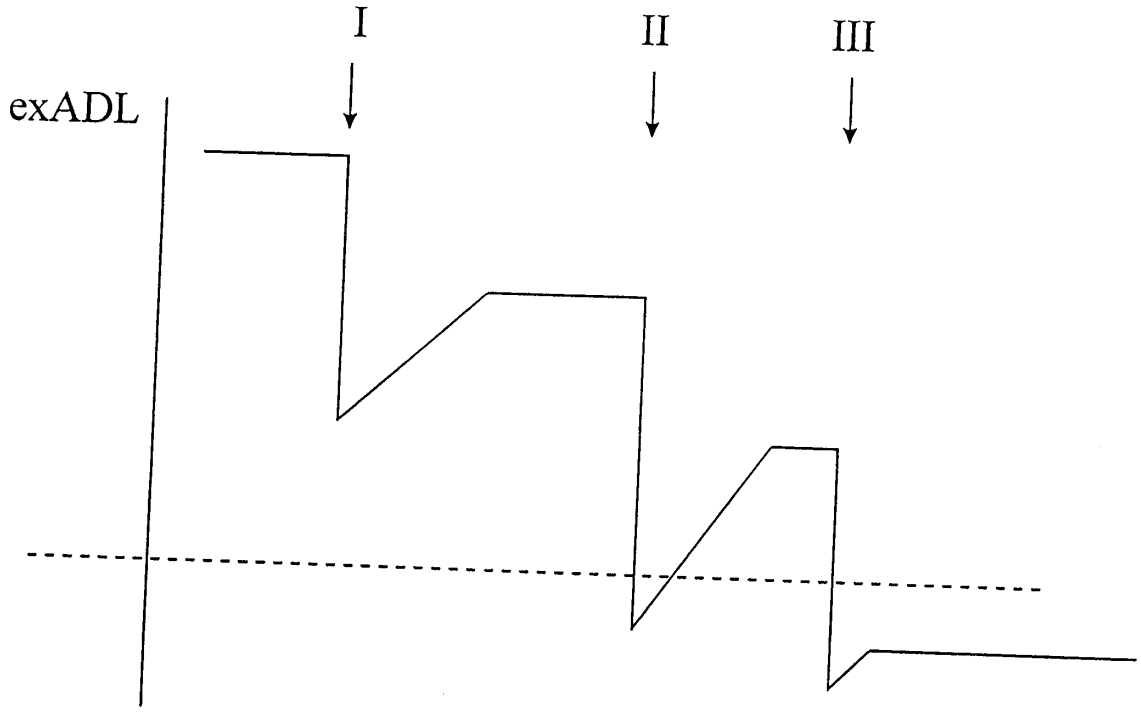
Case scenario I

Mr G suffered a stroke at the age of 80 years due to poorly controlled high blood pressure. He was discharged after six weeks from hospital, was able to walk with a stick and dress independently. Four months later he was readmitted with a fall and a fractured wrist - the fall was due to urinary tract infection, which had not been treated. After six weeks in hospital he was discharged to a residential home and only able to walk with a frame. Two months later he was readmitted with a pneumonia and was subsequently discharged to a nursing home, where he died two years later.

Case scenario II

Mrs T suffered a hip fracture at the age of 84 years. Previously well and fully independent, she was discharged from hospital after twenty days and her hip was repaired with a total replacement. She regained full mobility but suffered a further fall three weeks after being discharged and fractured her left wrist. She was able to stay at home with considerable community care support. Six weeks later, a further fall occurred with a minor head trauma. Medical investigations revealed a heart rhythm disturbance, which was successfully treated. No further falls occurred over the next three years.

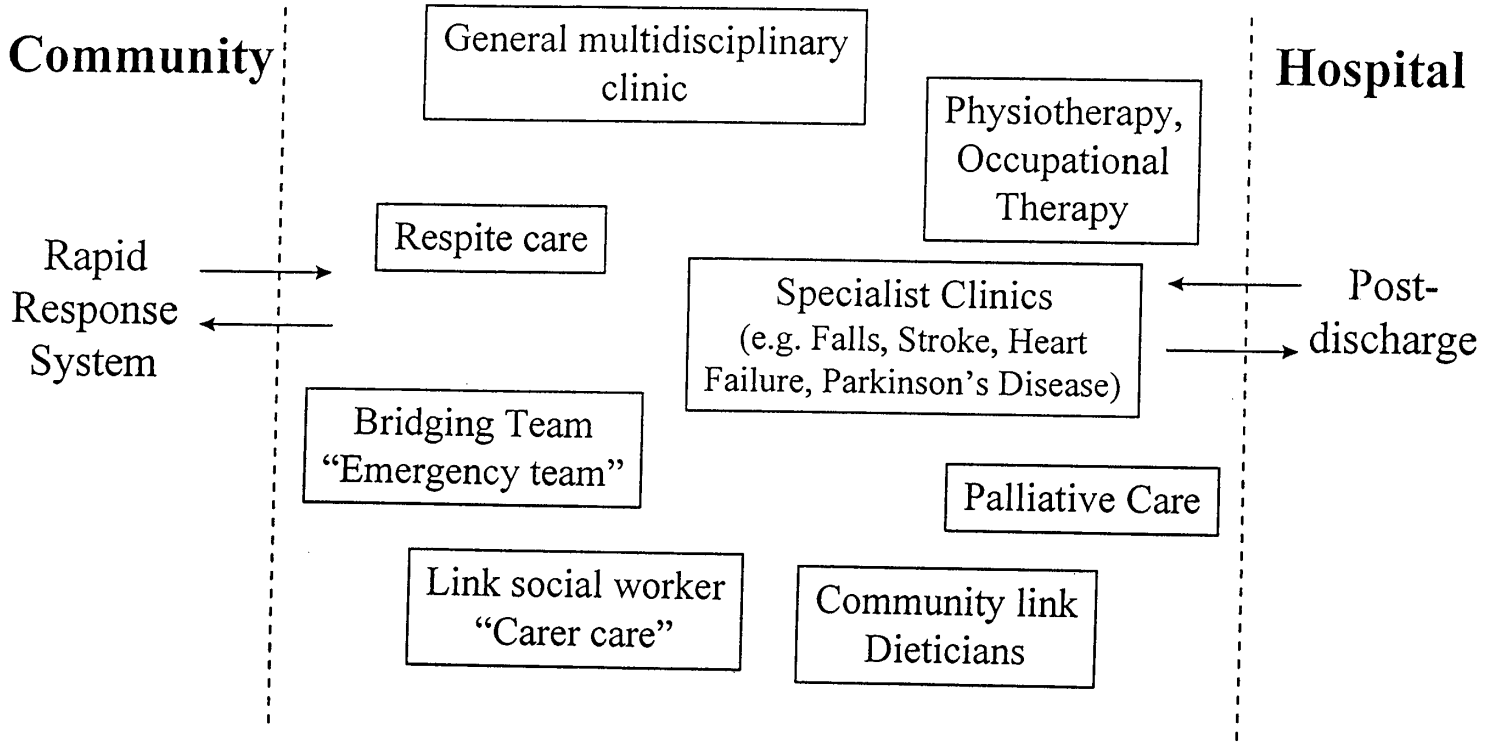
The course of decline



Strategies to prevent further physical deterioration

- Achieving full rehabilitation potential
- Minimise medical and accidental risks
- Improve access to medical assessment and treatment
- Target specific areas
  - e.g. falls, heart failure, osteoporotic fractures

The Medical Day Care Model



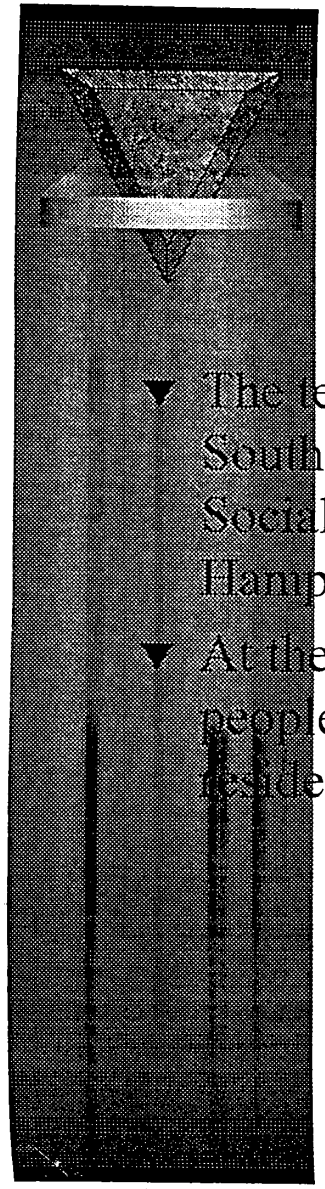
Case scenario III

Mr B is 89 years old and has been suffering from advanced Parkinson's Disease for the last three years. He is reviewed on a two-monthly basis in our Medical Day Unit and needs frequent treatment for chest infections and leg ulcers. He has however, maintained his mobility and is able to cope within his flat with a little help from his wife and a weekly visit from his district nurse. His mobility and physical state are checked by a specialised physiotherapist and he has needed three courses of short-term physiotherapy over the last three years - always after infections. He attends a respite home for two weeks every two months to give his wife a rest.

Summary

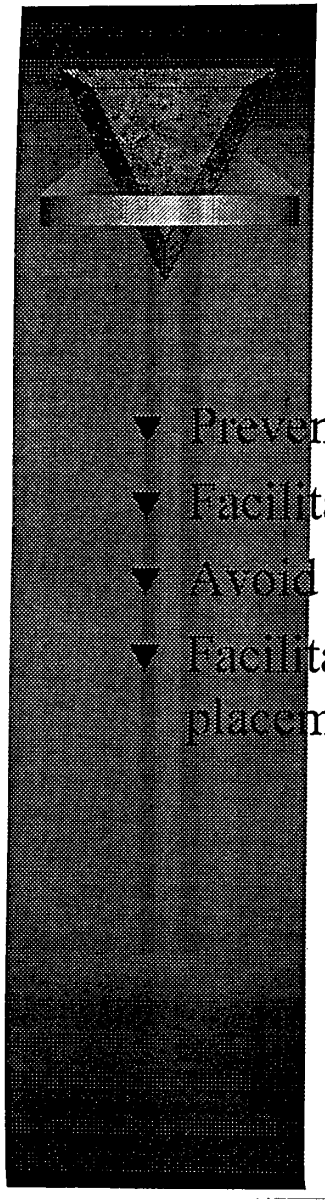
Rehabilitation of elderly people is characterised by recurrent "failures" due to disease. Integration of multidisciplinary services within Medical Day Care Units, provides the framework for a proactive and comprehensive care model with the aim to delay deterioration and maintain personal independence.

Helen Loten
CRT Portsmouth



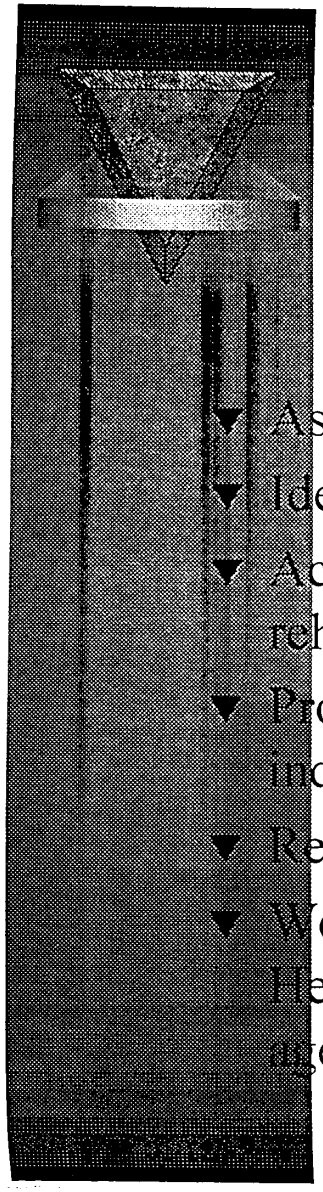
Market Summary

- The team has a district remit covering the Portsmouth and South East Hampshire Health Authority, involving the Social Services departments of both Portsmouth and Hampshire.
- At the present time the team provides a service to older people and their carers living in community settings and residential care where return home is planned.



AIMS

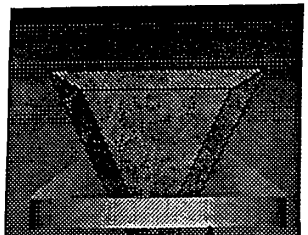
- Preventing inappropriate admissions to hospital
- Facilitate earlier discharges from hospital
- Avoid inappropriate stays residential and nursing homes
- Facilitate return home from recuperative short stay placements.



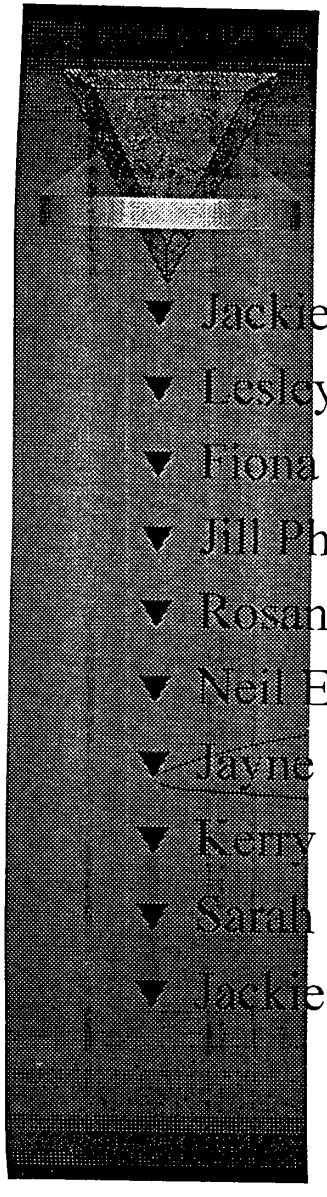
Core Functions

- Assess and establish a rehabilitation programme
- Identification and reduction of risk
- Active involvement and partnership of carers in rehabilitation programme
- Provision of appropriate resources to enable independent living
- Responding to need in a creative and flexible manner
- Working in partnership with colleagues within Health/SSD/independent sector and voluntary agencies

REFERRAL CRITERIA



- Aged 65 years and over
- Recovered from an acute illness
- Presently in hospital but no longer requiring medical intervention but requiring on-going rehabilitation within the home environment to facilitate discharge
- Requiring rehabilitation in order to return home from a recuperative short stay in a residential setting
- Have had frequent inappropriate admissions to hospital
- Requiring rehabilitation within the home environment to prevent an admission to hospital
- Demonstrate the potential to continue to improve in their physical and functional ability
- Have given their consent to admission to the project



The Team

- Jackie Lelkes - Co-ordinator
- Lesley Court - Senior 1 Physiotherapist
- Fiona Casserley - Senior 2 Physiotherapist
- Jill Phipps - Senior 2 Physiotherapist
- Rosanne Brown - Occupational Therapist
- Neil Evans - Care Manager
- Jayne Gentle - Home Economist
- Kerry Collins - Podiatrist
- Sarah Easton - Speech and Language therapist
- Jackie Rumer - Clerical support

Market Summary

- The team has a district remit covering the Portsmouth and South East Hampshire Health Authority, involving the Social Services departments of both Portsmouth and Hampshire.
- At the present time the team provides a service to older people and their carers living in community settings and residential care where return home is planned.

Pauline Riley
CARATS Primary Care Clinical Manager
Rotherham Priority Health NHS Trust

COMMUNITY ASSESSMENT REHABILITATION AND TREATMENT SCHEME

LOCAL PROBLEMS

- Ever increasing surgical waiting lists and EMA's.
- High elderly population.
- High level of chronic illness.
- York Hec. Report on Elderly and Medical Admissions.

Rotherham NHS Trust

The objectives of CARATS are:

- To prevent inappropriate admissions to, and reduce lengths of stay in acute hospital care.

- To prevent inappropriate long term admissions to Residential/Nursing Home care.

- To devolve care assessment and management of these patients to the Primary Care Team, while developing further multi-agency fieldwork staff's collaboration and sharing of skills.

- To identity local Community Care needs and utilise the extra resources to meet those needs.

Rotherham PRIORITY HEALTH NHS Trust

FOUR COMMUNITY BASED SERVICE AREAS DEVELOPED

- Fast response Service.
- 9 Bedded Residential Rehabilitation Unit.
  (Joint Health and Social Service Staffed and Funded)
- Day Care Rehabilitation Unit.
  (Joint Health and Social Service Staffed and Funded)
- Nurse Led Beds.
  (Utilising Independent Sector Nursing Home Beds)

FAST RESPONSE/NURSE LED BEDS

Eligibility Criteria

- **The patient would be admitted to hospital or stay in hospital for a longer period of time without CARATS intervention.**

- **The patient's GP accepts medical responsibility.**

- **The District Nurse accepts nursing responsibility.**

- **Patient's and carer choice is to be cared for at home.**

RESIDENTIAL/DAY CARE REHABILITATION

Criteria

- Normally aged 65 years and above.
- Change in ability to cope/function to their optimum potential, following illness/trauma/surgery/general deterioration.
- Have received any necessary acute treatment and are medically stable.
- Potential to benefit from short term rehabilitation (up to 6 weeks).
- Acknowledge and agree the financial implications for the social care element of this service.

INDEPENDENT EVALUATION

BY

YORK HELATH ECONOMIC CONSORTIUM

Evaluation Period

22 December 1999

to

31 March 1999

(15 months)

Fast Response Service (2)

- Overall average length of stay = 3.2 days, (or 2.7 days if those on scheme for more than 8 days are excluded.
  - falls = 3.0 days
  - terminally ill = 3.5 days
  - other conditions (incl. IV but excl. platelets) = 3.0 days

Nursing Home Convalescence

- Only operated between Dec 1998 – March 1999.
- 22 recipients, often very old and frail.
- Average length of stay = 8.0 days.
- Average Nursing Home cost per recipient = £344.
  - average cost per day = £43
  - average cost per week = £300
- When management costs are included, average total NHS cost per recipient = £425 - £450.
- Strong local support to extend scheme.

Residential Rehabilitation (2)

- Average length of stay = 23 days.
- 3/4 discharged to own home: 1/10 (re)admitted to hospital.
- Over 4/5 of those discharged home were still there after 6 months.
- Most others went into long-term care.

Rotherham
NHS Trust

DAY REHABILITATION

- Has taken longer to become established.
- Needs to be seen in overall context of Day Care Services for Older People in the Rotherham area.
- Scheme has increase in popularity during recent months.
- Over half of recipients had 11-15 attendance's; about 1/3 had 6-10 attendance's.
- Average NHS cost per patient approx. £550.

Key Issues

- Project Manager Essential.
- Time to prepare.
- Key Players on Steering and Implementation Group including GP's.
- Good communication systems.
- Fast tracking appropriate services.
- Address problems as soon as they occur.
- Collaborative working across all agencies.
- Marketing to stake holders.
- Commitment from all agencies to make it work.
- Flexibility - not age restrictive.
  - length of input.
- Evaluation.

Fiona Shield
Service Manager
Stone Rehabilitation Centre

Workshop: Rapid Response Keeping Rehabilitation
on the Agenda, 7 February 2000

National CRT Network Goal Study Day
8.12.99

WHAT ARE GOALS?

- Aims that reflect the needs identified by clients/carers and agreed by the professional staff as being achievable
- Goals should be functional/useful and therefore require the broad perspective/knowledge of the 'Team', not just individuals.
- Goal should be specific + fit situation/environment

CRT Network - January 2000

WHAT DID WE ALL AGREE?

- Use of Goal-Setting should be fundamental to the team approach
- Success in achieving Goals is an identifiable outcome of the Rehabilitation process
- Goals can change

CRT Network - January 2000

PROCESS

- The *process* of reaching the goal is as important as the result
- Goals should be set after comprehensive assessment
- Early stages in the process may be initial aims
- Effective networking with other disciplines/agencies is essential to identify the stages in the process

CRT Network - January 2000

WHAT IS REQUIRED?

Client-centred

- Client 'friendly' language is essential
- Client held notes

Inter-Disciplinary Team Skills

- Team building to facilitate inter-disciplinary working
- Team need to pull in the same direction, and have good communication
- Difficulties arise due to culture/pressures to identify uni-disciplinary outcome measures. These may conflict with Goals & team measures

CRT Network - January 2000

Training

- Goal-setting methods & recording
- Goal setting forums
- Recognition that ability to write goals is a continual learning process

Time-Scale

- Need to recognise limitations of ability to set long-term goals, when unable to predict the future

CRT Network - January 2000

OBSTACLES TO GOAL SETTING

Time:

- Time-limited intervention v Long-term goals

Team:

- Professionally-led v Client-led goals
- Uni-disciplinary/agency pressures, i.e. accountability, dept. standards etc.
- Carers with different agendas

CRT Network - January 2000

Resources:

- Stages in the process may not be resourced, e.g. specialism, time, equipment etc.

Location:

- Team base essential, as difficult for team to meet if members do not operate from same base.
- Right/best place for treatment, i.e. problems if home visits restricted, or if need a Centre for ADL work for clients in nursing/ residential homes and group work.

CRT Network - January 2000

ADVANTAGES OF GOAL-SETTING

For the Client;

- It's what the client wants!

For the Team;

- It requires inter-disciplinary working, i.e. skill-sharing, peer support across disciplines, less duplication

CRT Network - January 2000

For Managers;

- The process to achieve goals can provide 'hard-evidence' of need for resources and why goals not achieved

For all of us!

- It ensures that 'Rehabilitation' is understood/defined as a process that goes beyond the 'medical' model and encompasses all agencies required to achieve functional goals that improve client's quality of living

CRT Network - January 2000

EXAMPLES OF GOAL-SETTING

	Comments
1. G.A.S.	Time & training needs Goal is only 1 step away, so not very sensitive How specific is this? Are the components the same as steps? Feels like making figs for stats
2. Teler	Teler process liked, ie steps to achieve goal Can be used m/d & and u/d Client centred, adaptable, can give figs. Numerical relevance of unrelated issues/weighting

CRT Network - January 2000

3. Canadian Outcome Performance Measure	Numbered & weighted goals, relate to issues that are important to client
4. Informal scoring	Simple 'Yes/No'. Meaningful & popular

CRT Network - January 2000

WHERE NOW?

- Further sharing of information
- Establish basic standards/classifications
- Training: National, Local
- CRT Network looking into taking this forward through a Working Group

CRT Network - January 2000

Multi v Inter Disciplinary Goals

'John will sit in the right position holding a pen correctly and write a paragraph with less than 5% grammatical errors.'

'John will position himself so that he can hold a pen to write a message that can be understood by the reader.'