



**Joint Improvement Team
Intermediate Care Learning Network
Shared Learning and Development Event**

**Role of Intermediate Care in Supporting
Implementation of Rehabilitation Framework
'Co-Ordinated, Integrated and Fit for Purpose'**

June 2007

1. Introduction

The Joint Improvement Team established a national Intermediate Care Learning Network to support shared learning across health and social care services in Scotland.

The Rehabilitation Framework – “Coordinated, integrated and fit for purpose” sets out a number of recommendations and work strands relevant to the development and implementation of intermediate care services.

The Joint Improvement Team, in collaboration with NHS Quality Improvement Scotland and the Scottish Executive organised a national event on 21st June 2007. The aim of the event was to consult with practitioners on the role of intermediate care within the strategies recommendations and the actions required nationally to support implementation.

The event attracted a lot of interest across Scotland and was over subscribed with over 70 participants from health, social care services and other organisations, including voluntary agencies. The majority of participants were from health services.

The programme for the morning aimed to consider the role, scope and opportunities for intermediate care services in supporting integration, shared learning and implementation of the rehabilitation framework and the prevention of falls strategy.

2. Key Themes from the Presentations

2.1 Intermediate Care Learning Network, Role of Intermediate Care in supporting the implementation of the rehabilitation framework

Dr Margaret Whoriskey, Associate Director, Joint Improvement Team

2.1.1 Context

This presentation outlined the key drivers for health and social care Partnership working and in particular the new National Outcomes Framework for community care services, being implemented during 2007/2008. The role of intermediate care services requires to be considered in this context.

There are 4 high level outcomes:

- improved health;
- improved wellbeing;
- improved social inclusion; and
- improved independence and responsibility

and 16 measures. These are shown in table 1 below:

Table 1 – National Outcome Measures

1. % of community care service users feeling safe
2. % of users and carers satisfied with care package
3. % of users satisfied with opportunities or social interaction
4. % of user assessment completed to national standard
5. % of carers' assessments completed to national standard
6. % of people 65+ with intensive needs receiving care at home
7. % of people 65+ receiving personal care at home
8. % of carers who feel able to continue their role
9. Shift in balance of care from institutional to 'home based' care
10. No. of patients waiting more than 6 weeks for discharge to appropriate setting
11. % of care plans reviewed within agreed timescale
12. No. of people waiting longer than target for assessment, per 000 population
13. No. of people waiting longer than target time for service, per 000 population
14. No. of emergency bed days in acute specialties for people 65+, per 100,000 population
15. No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100,000 population
16. No. of people 65+ admitted twice or more as an emergency who have not had an assessment, per 100,000 population

These measures include existing targets relating to delayed discharge; repeat emergency admissions and provision of home care services. Achieving a good balance of care will require appropriate and effective 'step up' and 'step down' services (intermediate care) and the range of rehabilitation services to maximize independence and optimal functioning.

2.1.2 Intermediate Care Services

Definition of intermediate care is referred to in the Joint Improvement Team 'Intermediate Care' Scoping Report (www.jitscotland.org.uk) and the following definitions are appropriate to consider in context of Partnership working in Scotland.

“Intermediate Care can be described as those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team. This includes:

- *Intermediate care which substitutes for elements of hospital care (substitutional care); and*
- *Intermediate care which integrates a variety of services for people whose health care needs are complex and in transition. (complex care)”*
- *(Oxford and Anglia Intermediate Care Project, 1997)*

And

“A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation. It’s aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care”.

(Making Connections, Change Agent Team, 2006)

Services can be provided in:

Individual’s own homes including housing and very sheltered housing
NHS Day Hospitals and Day Centres
Designated residential and nursing homes
Community Hospital

and include:

Rapid response services/discharge teams
Intensive care at home schemes
Extra care housing/telecare initiatives
Innovative use of community hospitals
Community assessment and treatment teams.

Intermediate Care Services aim to have the following outcomes:

- Supporting more people at home
- Reduced time in hospital
- Increased independence
- Improved quality of care
- Reduced admission to residential/nursing care
- Faster access to some services
- Shift in care from acute to community settings
- Increased provision of local services

2.1.3 The JIT Intermediate Care Scoping Report provides an overview of key features of services in Scotland and what is required.

JIT is progressing a programme of work with the Intermediate Care National Learning Network and forthcoming events will focus on approaches to evaluation and the role of housing.

2.2 A Delivery Framework for Rehabilitation Framework

Dr Sarah Mitchell, Project Manger

Rehabilitation is a core element in the delivery of the Scottish Executive's plans to improve the health and well-being of the population of Scotland and will be instrumental in achieving some of the key national outcomes and targets that have been set for the NHS and local authorities.

The delivery framework was launched in February 2007. It has been developed by the Scottish Executive in partnership with a wide range of stakeholders, including individuals who use services, unpaid carers and rehabilitation providers in health and social care. A National Steering Group and three Action Groups were established, each chaired by a service user. The Steering Group and Action Groups worked in support of the National Project Officer during the engagement process and the production of successive drafts. The Framework was launched in February 2007.

2.2.1 The process of developing the framework involved:

- a thematic analysis of the evidence by the Scottish School of Primary Care;
- a series of consultation events with those who use services;
- a consensus event with health and social care professionals;
- a three-month national consultation on a draft framework document.

The purpose of this delivery framework for adult rehabilitation is to give strategic direction and support to all health and social care services and practitioners who deliver rehabilitation services to individuals and communities. The document focuses on core principles of rehabilitation specifically as they relate to older people, adults with long-term conditions and people returning from work absence and/or aiming to stay in employment.

2.2.2 The framework:

- concentrates explicitly on the added value offered by rehabilitation through earlier anticipatory interventions and the prevention of unnecessary admissions to hospital or other care environments;
- explores how rehabilitation can produce health gains for individuals and communities through enabling return to productive activity and employment;
- provides guidance to underpin the development of rehabilitation in a multi-disciplinary, multi-agency context;
- offers a clear vision to individuals, carers and services in delivering this agenda.

The vision underpinning the framework is the creation of a modern, effective, multi-disciplinary, multi-agency approach to rehabilitation services that are flexible and responsive in meeting the needs of individuals and communities in

Scotland. These services will be facilitated by dedicated Rehabilitation Co-ordinators , who will play a key role in:

- mapping existing rehabilitation services in health and social care;
- re-designing services with the support of a rehabilitation improvement network;
- integrating health and social care rehabilitation services;
- promoting case management in the rehabilitation team.

This rehabilitation framework links into on-going work in relation to anticipatory care/early interventions, long-term condition management and unscheduled care. Effective implementation of this framework together with better co-ordination of resources, will **help reduce emergency admissions, length of stay and delayed discharges**. This will be made possible through **better identification and management of the ‘at risk’ population and improved access to rehabilitation professionals and the wider primary care team**. It will also **ensure more effective engagement of service users and their carers** in decision making and **enable people, wherever possible, to remain in their own homes**.

Integrated service redesign and role development is key to putting the rehabilitation journey at the heart of systematically planned services. This will enable multi-disciplinary, multi-agency teams to maximise the benefits of existing models of service and create new approaches that focus on the shift from ‘care’ provision to ‘enablement’ and rehabilitation, using the expertise of these professions and of the whole team to work with individuals and carers to best effect.

There are 5 key actions within the Framework as well as 32 recommendations. The five key actions are outlined below:

Five key actions

1. A **National Rehabilitation Implementation Group** will be formed to oversee the introduction of the rehabilitation models and other recommendations from the delivery framework. The group will report jointly to the Scottish Executive Health Department and the Social Work Services Policy Division, Scottish Executive Education Department.

2. Local **Rehabilitation Co-ordinator Posts** will be established and funded through the Scottish Executive Health Department and Scottish Executive Education Department. Post holders, working with the rehabilitation models, will provide leadership, direction and strategic co-ordination at local level and will work with the National Rehabilitation Group to ensure the rehabilitation models and framework recommendations are delivered locally. The co-ordinators will

work closely with the key stakeholders to facilitate the required organisational changes.

3. The Chief Health Professions Officer will work with the Improvement and Support Team and the Joint Improvement Team to explore the development of a **Rehabilitation Improvement Programme** to shape delivery of rehabilitation services nationally, based on the rehabilitation models. The programme will work with the relevant agencies to ensure alignment with existing education and improvement initiatives.

4. The Scottish Executive Health Department will work in partnership with NHS Education for Scotland, NHS QIS and the regional research consortia to develop managed knowledge network (MKN). This MKN will facilitate effective access to the knowledge and evidence base for rehabilitation and the sharing and generation of new knowledge.

5. The Scottish Executive will bring together national and international rehabilitation research experts for a **Rehabilitation Research Consensus Event** that will explore gaps in the current research literature and make recommendations for future research bids.

Sarah qualified as a physiotherapist in 1988 from Queens College Glasgow. She completed her Masters in 1994 into the effects of exercise on post-menopausal Osteoporotic women. She was the lead author of the National Physiotherapy Guidelines for the management of Osteoporosis, which were published in 1999. She was also on the development group for the SIGN guidelines on the management of osteoporosis. She completed her PhD in 2002, which investigated the effects of strength training on patients following proximal femoral fracture. More recently she was a member of the NICE development group for the Falls Guidelines.

Sarah was the Physiotherapy Manager for North Glasgow University NHS Division until 2006 when she took up a secondment at the Scottish Executive Health Department as the Project Manager for the Delivery Framework for Adult Rehabilitation, which was launched in February 2007.

2.3 Prevention of Falls in Older People. A Community of practice for Falls June Wylie, Professional practice Development Officer, AHPs Quality Improvement Scotland

The prevention of falls is increasingly recognised as an important area for targeted intervention by health and social care services due to the considerable physical, social and cost implications of increasing numbers of elderly fallers.

2.3.1 The scale of the problem

Falls are an international concerns, which is highlighted by the level of international literature and the World Health Organisations paper on the main risk factors in older people and the most effective interventions to prevent falls¹ When considered on a national and international level the scale of the problem is significant

- Approx 10% of UK ambulance service calls are to people over 65 who have fallen, about 60% of cases are taken to hospital
- Falls are the leading cause of injury and deaths amongst people over 65 and older, half occur in their own home
- Older adults who falls once are two or three times as likely to fall again within a year
- Approx 50% of older people in residential care facilities fall at least once a year
- Falls are recorded as a contributing factor in 40% of admissions to nursing homes
- The incidence of falls can double after older people are relocated to a new environment and this returns to baseline after the first three months

2.3.2 International activity

Countries across the world are actively working to reduce the incidence of falls with some notable national programme of work

- Canada (British Columbia) Falls and Injury Coalition
- USA National Action Plan (2005)
- Australia - National Falls Prevention Programme(2004)

2.3.3 Falls Services in Scotland

NHS Health Scotland in collaboration with NHS QIS commissioned a mapping exercise to identify the current falls prevention activity and Scottish Context in relation to falls prevention in 2007. A summary of the key finding will be circulated to health boards in September 07.

Summary of Key Issues:

- Need for a culture change in relation to falls
- Need for clear direction from policy, board and local authorities
- Falls coordinators/leads are a crucial link
- Need for standardised assessment tools and data capture

¹ Skelton D, Todd T. What are the Main Risk Factors for Falls Amongst Older People and what are the Most Effective Interventions to Prevent these Falls? How Should Interventions to Prevent Falls be Implemented? Copenhagen: World Health Organisation. 2004.

- Sharing and dissemination strategy
- Available evidence base and best practice
- Training for staff
- Health Promotion
- Primary prevention as well as secondary prevention

2.3.4 The Policy Context in Scotland

- All Our Futures: Planning for a Scotland with an Ageing Population (2007)
- Delivery Framework for Adult Rehabilitation (February 2007)
- HDL Rehabilitation and Falls (2007)
- SEHD Falls Working Group (April 2006)
- Changing Lives (2006)
- National Framework for Service Change (2005)
- Delivering for Health (2005)
- Taking Positive Steps to Avoid Trips and Falls' (February 2003)
- Adding Life to Years: Report of the Expert Group on Healthcare of Older People (January 2002)
- Falls Prevention Conference (November 2002)
- Joint Future (2000)

2.3.5 Rehabilitation and Falls HDL 2007

In February 2007 the SEHD issued a HDL on falls and rehabilitation with a series of recommendations for boards and local authorities. In relation to falls the HDL stated that:

- NHS Boards need to have a combined falls and bone health strategy which CHP will implement
- CHPs need to appoint a falls prevention lead or coordinator to work alongside the rehab coordinators
- CHPs need to develop an operational falls prevention and bone health implementation strategy

2.3.6 Next Steps

As highlighted by the international literature and the mapping work carried out for NHS Health Scotland leadership, partnership and education are three areas where national and local support are required if falls services are to be successful. In addition to the falls HDL requiring actions at board and local authority level there are plans for support at a national level. NHS QIS in partnership with NHS Health Scotland and NHS Education (knowledge services)

and the SEHD will develop and provide a programme of support that will dovetail with the implementation of the rehabilitation framework programme.

- Falls Programme Manager

A full time falls programme manager will be appointed in the Autumn of 2007 by NHS QIS to lead a programme of work over a two year period in partnership with the SEHD, NHS Education and NHS Health

- Managed Knowledge Network

SEHD, NHS Education and NHS QIS will support the development of a managed knowledge network on the library to allow health and social care staff access to a wide knowledge base and range of resources to support them in delivering evidence based falls and rehabilitation services.

- Community of Practice for Falls

The function of the community is to develop an environment where members can support and learn from each other. By exploring the formal evidence base as well as the social and environmental knowledge, the community will identify how best to share this new knowledge with relevant organisations and individuals to make it operational and meaningful.

June Wylie is the Professional Practice Development Officer for Allied Health Profession based at NHS Quality Improvement Scotland. June has responsibility of the Practice Development Network for Allied Health Profession and leads a programme of work based on clinical improvement priorities identified by allied health professions. Falls was one topic identified by the AHP network in 2005. June is an Occupational Therapist with over 25 years experience in a range of health care settings.

3. Workshops

Workshop groups focused on specific recommendations from the framework and the Falls HDL. Nine facilitated groups were provided with a recommendation & a related question from either the Delivery Framework for Adult Rehabilitation or a question relevant to Falls from HDL 92007 13 Prevention of Falls in Older People. Each group was asked spend time discussing these and to produce a list of three development support needs relevant to intermediate care for their allocated recommendation. These were fed back to the wider group at the plenary session.

The groups were asked to focus their discussions on integration, shared learning and development in the developing of the rehab framework and prevention of falls. This included consideration of links to the Intermediate Care Learning Network and partnership working in the delivery of each recommendation.

3.1 Outcomes from the Workshop Groups

3.1.1 Recommendations on Access, Rehabilitation Framework

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Group 1

Recommendation 1.5 :

“Health and social care providers should address transitions of care for older people and those with long-term conditions, particularly in relation to discharge from hospital or specialist rehabilitation services”.

Timescale – by end of 2008.

Facilitator – Jane Arroll – General Manager (North) Rehabilitation and Assessment Directorate – Greater Glasgow Health Board.

What are the principal challenges facing partnerships in addressing the transition of care?

The top development support needs for this recommendation to be achieved.

- Support to enable redesign across acute community and local authorities – shifting resources
- Develop a joint training pack – for local communities, including training around the rehab recommendations
- Identify the key elements for an effective rehab team
- Clarify the roles and remits of current multiple teams/services
- Robust case finding and anticipatory care plans
- Develop capacity in the community to meet demand

Group 2

Recommendation 1.6 :

“NHS Boards and local authorities should consider the introduction of direct access to rehabilitation services provided by individual AHP and social work professionals as part of an integrated care pathway”.

Timescale: by end of 2008.

Facilitator – Judy Gibson, JIT Associate and Head Occupational therapist, NHS Lothian.

What should direct access to rehabilitation services in an integrated service look like?

The top three development support needs required to achieve this that the Group identified were:

- Single point of entry across health/social intermediate care – umbrella approach to target appropriate input
- Education/information for people , GPs etc on services available, access etc. – home carers, housing – support direct access
- Communication across agencies – IT to support; link to other strategies, initiatives. Use of internet to link information. Role of NHS 24 - as hub of information

3.1.2 Recommendations on Service Provision, Rehabilitation Framework

Groups 3 & 8

Recommendation 2.2 :

“NHS Boards, particularly CHP’s and local authorities should identify how anticipatory care and rehabilitation services can be focused on “at-risk” individuals to provide early interventions, prevent unnecessary admissions to hospital or care facilities and facilitate smooth transitions from hospital or specialist services”.

Timescale – end of 2008

Facilitators – Alex Davidson – JIT Associate
Bob Devenny -

What are the critical factors for anticipatory care and rehabilitation to successfully benefit “at risk” individuals through early intervention, preventing admission and facilitating smooth transitions?

The top development support needs for partnerships that the group highlighted were:

- Good in reach with clear pathways of care
- Robust out of hours, multi agency services
- Model with a continuum of resources – generic to specialist
- Expand current risk tools – tapping into wider team support enabling a wider vision of the challenges/needs of individuals.
- Financial shift from acute to community – with bridging to enable this.
- Return to mainstream services – how can this be enabled, supported, reviewed?
- Communication requires improvement across all services

3.1.3 Recommendation of Enablement and Self Managed Care from Rehabilitation Framework

Group 4

Recommendation 3.4 :

“People with long-term conditions and rehabilitation needs should have access to psychological expertise to ensure that individuals receive appropriate assessment and intervention to overcome emotional, cognitive or behavioural barriers to their participation in rehabilitation and to maximize their progress”.

Facilitator – Trudy Marshall

What are the key issues, which need to be addressed in integrated working in order that access to psychological expertise can be delivered to best effect for those individuals requiring this intervention?

Identify the top three development support needs for this to be achieved in integrated working?

- Access – wider need to take account of psychological needs across professionals – cultural shift
- Training and development – all staff - understanding that it is good practice to listen
- Health academy – training to return to workplace

3.1.4 Recommendations on Comprehensive and Evidence Based Services from the Rehabilitation Framework

Groups 5 & 6

Recommendation 4.1 :

“NHS Boards, particularly CHP’s and local authorities need to apply a whole-systems approach to the provision of rehabilitation services, linking together early intervention/rapid response services with community rehabilitation teams, specialist rehabilitation and nurse/therapist-led units, community hospitals and integrated care to provide seamless transitions of care”.

Facilitators – Dr Sarah Mitchell – Project Manager, Rehabilitation Framework

Dr Anne Hendry – JIT Associate and Consultant Geriatrician,
Lanarkshire

What are the key factors for success which CHP's and Local Authority's need to consider in delivering whole systems approach to provision of rehabilitation services?

The development support needs for the parties to achieve this that the two groups identified were:

- Pulling teams /services together & focus on enablement
- Utilising existing community resources – e.g. day hospitals could be redesigned to expand into community resource centre
- Demonstrate /evidence of whole system working – need to evaluate & share learning
- Development of skills, knowledge, use and quality of SSA across system
- Consider contribution of transport, tele health, equipment provision etc and the development of a hub model to support delivery across all systems.
- Culture/attitudes – dependency not enablement – staff, carers, patients – post qualification training /development – peers, mentors (hospital/community interface)
- More flexible services – OOH etc
- Early intervention and access to services - flagging system

3.1.6 Prevention of Falls in Older People from HDL 92007

Groups 7 & 9

Facilitators - June Wylie, Lead AHP Quality Improvement Scotland
Alistair Nobel

An integrated falls service.

What are the key issues to be addressed in the planning and delivery of an integrated falls prevention service?

The top development and support needs in relation to the integrated agenda that were highlighted were:

- Data and information - A&E; GPs etc on falls
- Use of wider resources – community services etc
- Establish local networks – rural issues - umbrella for all services health, social care, voluntary etc
- Locality responsibility for pathway
- Single records
- Change medical model – culture – enablement not sick

3.2 Further Issues

A number of Further general issues raised by the groups also included:

- A desire to focus on avoiding transitions and in preference, where appropriate supporting people in their own homes.
- Consideration of models for rural and remote areas.
- Rehabilitation and home care services, the transition and changing role of carers to enablement
- Time limited services, hand-overs, gaps and role of voluntary services in supporting people.
- Culture and attitudes

4 Summary

4.1 The event generated a considerable amount of interest, particularly from healthcare staff and further work on the subject of partnership working linked to the rehabilitation framework and falls is strongly indicated.

The recommendations from the workshop groups provide a comprehensive outline of priority action points which will be extremely useful in guiding the partnerships during the phase of implementation.

In addition to the key recommendations a number of overarching issues were also identified and these included;

4.1.1 Requirement to develop a more **integrated approach** to the range of services and teams providing intermediate care and rehabilitation services across health and social care. This should extend to include the role of wider service providers: e.g. housing, community leisure etc. One option is to identify a framework to assist services to undertake a pathway mapping approach which could be taken forward by doing some focused work in one or two areas.

4.1.2 Provision of **flexible, robust, out-of-hours services**. This links to other work underway relating to developments, such as telecare and integrated out-of-hours services. There is strong support for Shifting the Balance of Care and Resources/Expertise, to increase support to people in local communities and in their own homes. This links with Shifting the Balance Strategic Group.

4.1.3 **Education and training**. There are strategic issues around education and training for all staff, including users and carers.

4.1.4 Opportunity to inform practice through implementation of the **National Outcomes Framework**, supporting a culture of enablement and support.

4.2 Next Steps

The core group will further review the findings from the event and current plans include the following:

- 4.2 Review the recommendations in the context of other relevant strategic priorities across health and social care. This will include identification of, where appropriate, direct links to related work ongoing and recognition of good practice examples.
- 4.3 Links to the National Outcomes Framework will be further scoped. Linking the rehabilitation and falls recommendations to development work already in the implementation plan for the outcomes framework will be considered and included where possible.
- 4.4 Finally, work on the education and training needs to deliver the key recommendations of framework will be a key component of the next phase of the workplan.