

# **Mapping Local Rehabilitation and Intermediate Care Services**

**A whole systems approach to understanding service capacity and planning change**

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*King's* **Fund**

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Jan Stevenson  
July 2001

***Why map rehabilitation and intermediate care services for older people in a local health and social care community?***

The agenda for re-shaping services for older people has been clearly set out by the Government in the NHS Plan and the National Service Framework for Older People. The Government recognises that many successful local intermediate care and rehabilitation schemes have been developed and that the challenge now is to provide a range of integrated services.

Managing strategic development and operational change using a ‘whole systems’ approach will be key to the development of a range of flexible intermediate care and rehabilitation for older people.

HSC 2001/01: LAC (2001)1 *Intermediate Care*, issued on 19 January 2001, requires the NHS and councils, in planning the best balance of intermediate care services locally, among other things, to:

*Map current levels of capacity, patterns of service provision, A&E attendances, acute admissions (in particular those with very short or very long stays), bed occupancy rates and long-term care placements for older people in their area, including where referrals are generated and what sorts of conditions are triggering these referrals.* (para 24. Planning development of intermediate care)

This is important for a number of reasons:

- To be clear about where older people’s needs are currently being met, so that the likely or expected impact of proposed changes can be tested in the context of the whole service system.
- To identify the potential contribution of services and activities not readily identified as offering rehabilitation (e.g. leisure and recreation programmes) to meet older people’s rehabilitation needs.

## 2 Mapping Local Rehabilitation and Intermediate Care Services

- To understand how, and the points where, older people might first access the service system and how they move through it as their needs change.
- To identify gaps and pressure points in the service system.

### ***How to go about mapping local rehabilitation and intermediate care services***

Start by getting a clear picture of where older people's needs are, or could be met, in the local service system. Include details of all services and places where care and support are offered, even though their relevance to rehabilitation and intermediate care may be tenuous at a first glance. ('Good' care packages are those that are tailored and planned for each individual; if a holistic approach is being taken, then those putting packages together need to have a wide knowledge and understanding of the potential contributions of a range of services, leisure opportunities, sources of advice, etc.)

#### A joint approach

It is important to involve people from different agencies and older people themselves in this exercise, as each will bring a different perspective and different local knowledge to it.

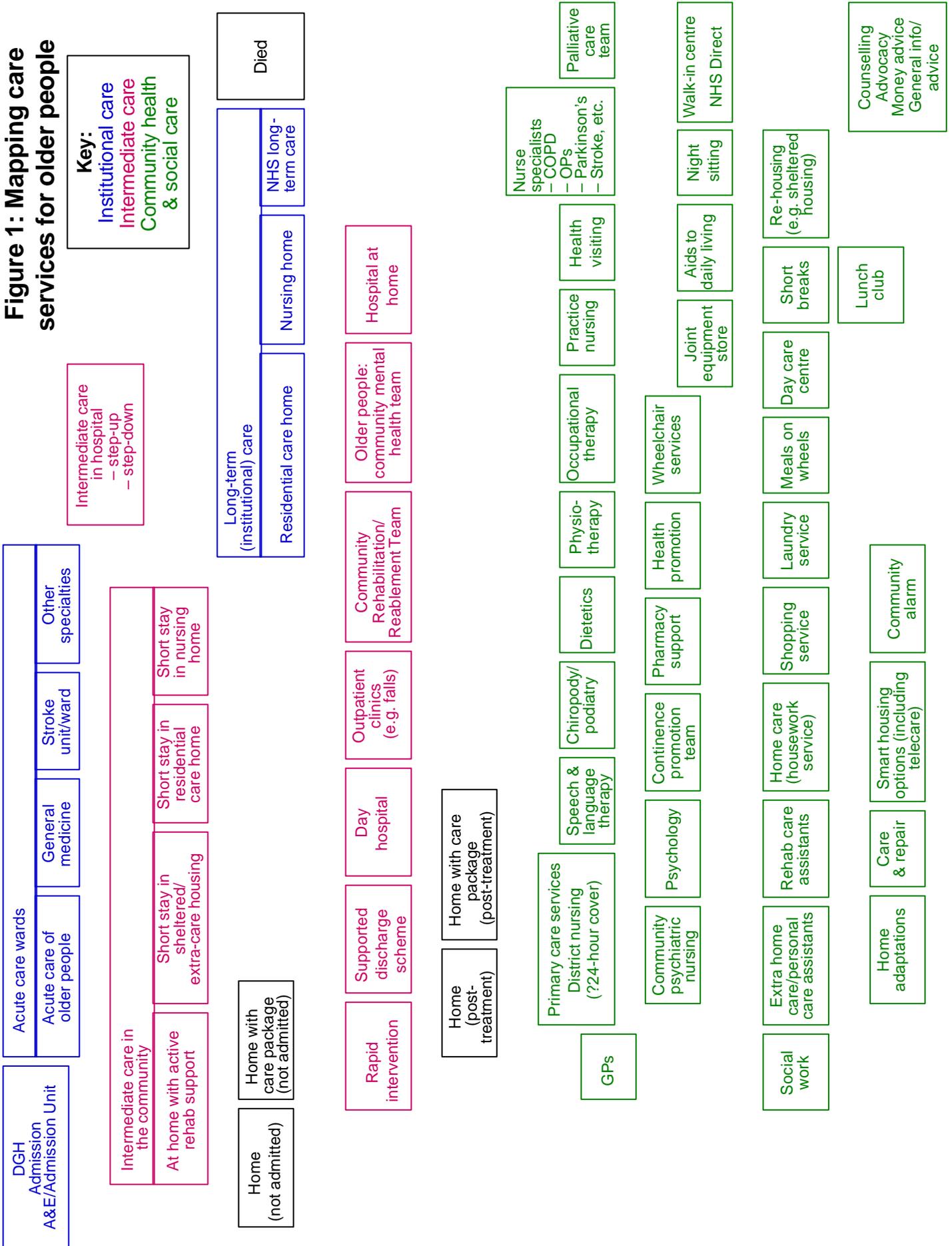
#### An example

As part of the work to help support the longer-term development of older people's services, the London Capacity Development Team<sup>1</sup> members put together a map of a hypothetical service system. This is shown in Figure 1 (opposite).

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<sup>1</sup> Over the winter of 2000/01, as part of the national initiative to expand capacity in the care system, the Department of Health funded regional teams of change agents. The London Capacity Development Team provided consultancy support to London's care communities.

**Figure 1: Mapping care services for older people**



### ***Questions to ask about how the local system works***

Once a local planning team has its outline mapping exercise completed in this way, there are a number of other key items of information/local intelligence that can help in interpreting how well (or poorly) the system is operating.

Sometimes it will be helpful to plot additional information onto transparent pages that can be overlaid on the basic service map, to help develop an understanding of how the system fits together and to analyse what is happening. Consider the following:

#### **Gaps**

- Check to see if there are any gaps in the system. (Comparing your map with the one shown in Figure 1 may help you to spot gaps.)
- Are older people with particular rehabilitation or intermediate care needs either not given support at all, or is it provided in a setting or by a service not geared to meeting those needs in the most appropriate way/place? For example, is there a choice of intermediate care settings for those who might benefit, or are older people simply moved to one place locally that offers intermediate care? Are services that are labelled 'rehabilitation' or 'intermediate care' able to provide it? Check staffing levels, training, access to therapists, etc. (See Appendix 1 for suggested categories of rehabilitation needs.)

#### **Access and equity**

- Are there fewer people accessing the system than expected in relation to the local population profile? For example, are local ethnic groups under-represented?
- Identify the points where people access the system. Who are the referrers? Are sources of referral, or referral patterns, different for different parts of the system? Are any of the referrers acting as 'gatekeepers'? Are referrals appropriate?

- Check eligibility criteria for services. Are there explicit exclusions, such as people with dementia? Are their needs catered for appropriately elsewhere in the system? Does everyone who needs to know have the information? If there are no clear criteria, these need to be developed.

### Bottlenecks

- Are there any points of access that have waiting lists, or points that are perceived as bottlenecks in the system? If there are, what impact do they have on the system overall? For example, are there lengthy waits for community equipment services to support hospital discharge? (You might want to check whether any impact will affect the ability of the local community to meet the government performance targets. See Appendix 2 for a summary of the Performance Indicators and milestones that relate to rehabilitation and intermediate care for older people.)

### Moving through the system

- Are there agreed user/patient pathways through the care system based on assessed need? Does everyone who needs to know have the information? Are there agreed protocols for transfers between different parts of the system? If not, these will need to be developed.
- Are there cross-boundary issues for some service users? Are these explicitly dealt with in eligibility criteria and transfer protocols? If not, these will need to be addressed.

### Impact of local policy

- Are there local policies that impact on patient care and pathways? For example, local authority charging policies can deter people from accepting some services.

### ***What will you learn?***

The level of sophistication and detail that can be achieved in this will depend on:

- the amount of time and resources that can be given to the work
- the information systems of various local agencies, how comprehensive they are, and how easy it is to search and retrieve data.

An interesting example of a comprehensive approach to collating and analysing data on service provision to people over the age of 75 within a single primary care group area (the London Borough of Newham) is described briefly in Appendix 3.

The fuller the picture that is obtained, the easier it will be for the local planning partners to adopt an approach to developing and re-shaping services for older people that takes account of the whole system. Adopting such an approach should make the relationships between different parts of the system more transparent. It should be possible to devise a vision of the future pattern of care that might best meet local population needs. The effects of proposed changes can more easily be predicted in advance and tested after implementation. Thus, managing a stepped implementation programme towards the agreed vision should, over time, be a simpler task than might otherwise be the case.

## Appendix 1: What is intermediate care? Looking at needs

It is helpful to consider where particular types of rehabilitation needs are met, rather than simply recording services labelled ‘rehabilitation’ or ‘intermediate care’. Some work undertaken in Sheffield last year provides some useful pointers about how to approach this.

The Sheffield planning partners wanted to review existing opportunities for intermediate care using a whole systems approach. They aimed to identify both gaps in the system and points where intermediate care could be offered in a setting more appropriate to a person’s needs, rather than adopting the more common approach of fitting people into the services provided.

During this planning process, it became apparent that when they focused on existing local services, the planning partners’ thinking was constrained, so the group decided to consider people’s needs and where they might best be met. Eight broad categories of care needs were defined in order to clarify the needs of people with disabling conditions.

In Figure 2, the eight categories are arranged in accordance with expected user numbers in each group, with the largest group, ‘prevention and maintenance’, at the top. The places where people’s rehabilitation needs might be met are listed along the top. By considering if and where these needs are *currently* being met, and where they might *best* be met if alternative services were in place (or care pathways managed differently), potential for change can be identified.

For the full paper, see ‘What is intermediate care? Looking at needs’ by Pam Enderby and Jan Stevenson. *Managing Community Care* 2000; 8 (6): 35–40.

For other useful approaches see:

### ***Intermediate care: classification of terms***

This new guide is seen as complementary to the intermediate care Circular. Entries for particular services such as rapid response, supported discharge, hospital at home describe: purpose and aims; examples of appropriate patients/conditions, effectiveness/ evidence and good practice/level of evidence. It was produced by the NHS Executive South West Regional Office and the Social Services Inspectorate. Available on the NHS Executive South West Regional Office web site at: [www.doh.gov/swro/intermediatecare.htm](http://www.doh.gov/swro/intermediatecare.htm) (link at bottom of page).

### ***Balance of Care approach***

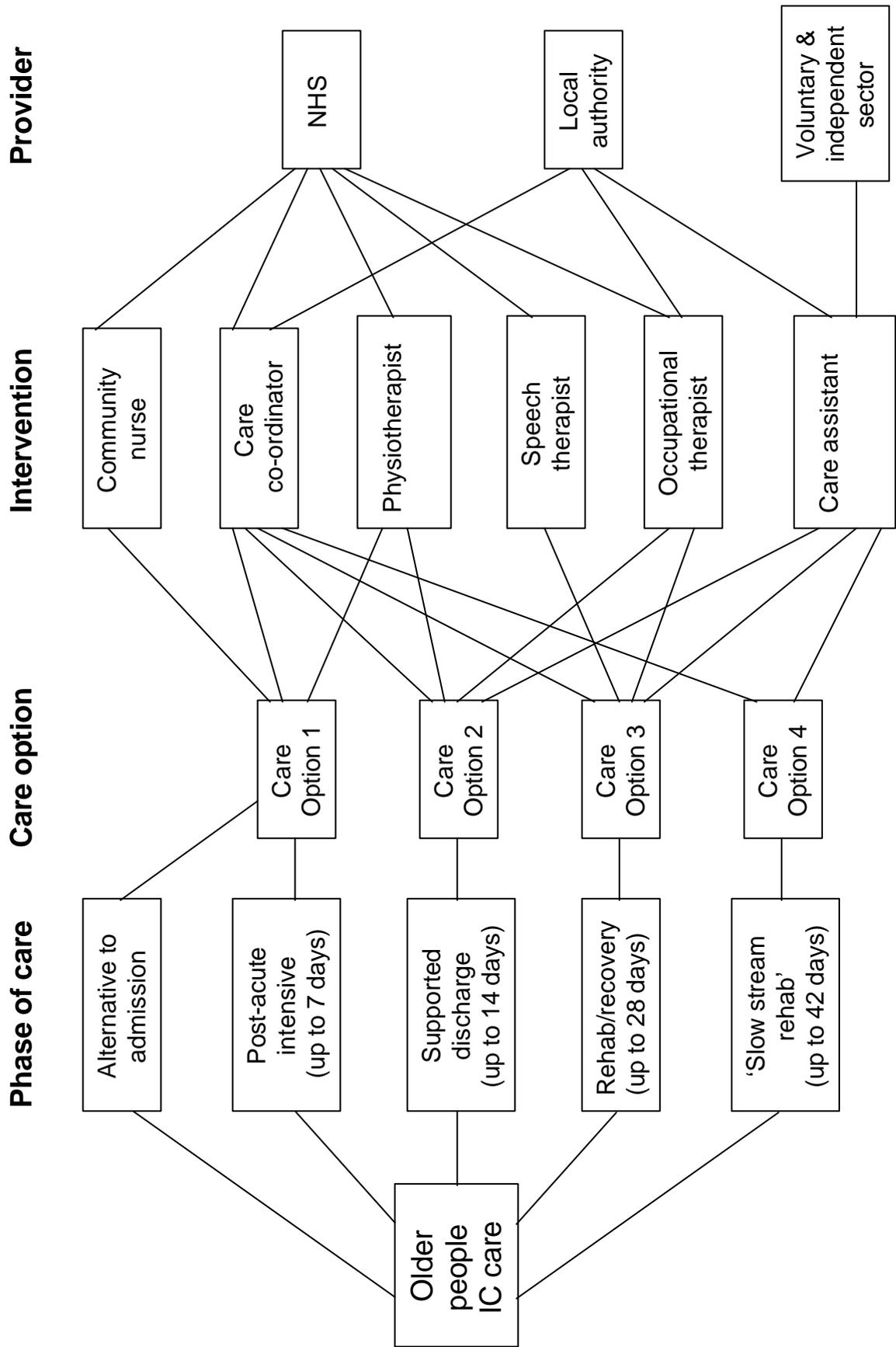
This approach takes the needs of older people as its starting point. Working with local stakeholders in workshops, a set of dependency groups are defined and populated. The resource consequences of different ways of providing care for these groups can then be explored using a computer model. This enables volume, costs and types of services to be calculated, as well as indicating the potential impacts for the different organisations involved. The generalised structure of the Balance of Care model is shown in Figure 3.

See Forte P. Planning intermediate care: the balance of care approach *Rehabilitation Development Network News Update* 2001; 6, (May) p6, or contact Dr Paul Forte, e-mail: paul@paul40.demon.co.uk; Tel 020 7359 6820.

									At home (including nursing home, residential care & sheltered housing)
									Day centre
									Day resource centre
									Day hospital
									Outpatient clinics
									Short-term residential care home
									Short-term sheltered housing
									Short-term nursing home
									Short-term community housing
									Post-acute nurse-led ward
									Rehabilitation ward
									GP unit
									Specialist unit
									Acute ward
									Geriatric unit
									Hospital assessment unit
									Orthopaedic ward
									General medical ward
									Regional rehabilitation unit
Rehab for complex difficulties									
Medical care alongside rehabilitation									
Specific treatments for one condition									
Intensive rehabilitation									
Regular rehabilitation									
Slow-stream rehabilitation									
Convalescence									
Prevention & maintenance									

**Figure 2: Categories of need and settings for care: matching rehabilitation needs with service settings**

**Figure 3: The Balance of Care approach**



## Appendix 2: Rehabilitation and intermediate care. Performance assessment: selected indicators

Social Services PAF 2000/01 <sup>1</sup>	NHS Performance Indicators 2000/01 <sup>2</sup>	Interface Indicators 2000/01 <sup>1</sup>
<p><b>C26</b> Admissions of supported residents (65+) to residential/nursing care</p> <p><b>AC-C3</b> Number of people supported by LA in residential care (65+)</p>	<p>Chronic care management: age/sex emergency admission rates:</p> <ul style="list-style-type: none"> <li>- asthma</li> <li>- diabetes</li> </ul>	<p><b>A5</b> Emergency admissions (75+)</p> <p><b>D41</b> Delayed discharge (75+)</p>
<p><b>C32</b> Older people (65+) helped to live at home (BV)</p>	<p>Discharge times following admission</p> <ul style="list-style-type: none"> <li>- stroke (50+) within 56 days</li> <li>- fractured neck of femur (50+) within 28 days</li> </ul>	<p>Average growth (between 2000/01 and 2001/02) in per capita rate of emergency admissions (75+) is less than 2%.</p>
<p><b>C33</b> Avoidable harm for older people (falls &amp; hypothermia)</p>	<p>Discharge times following admission</p> <ul style="list-style-type: none"> <li>- stroke (50+) within 56 days</li> <li>- fractured neck of femur (50+) within 28 days</li> </ul>	<p>Rate of emergency re-admission within 28 days of discharge does not increase.</p>
<p><b>D38</b> % of items of equipment (£1000 or less) delivered within 3 weeks (BV TQ)</p>	<p><b>D38</b> % of items of equipment (£1000 or less) delivered within 3 weeks (BV TQ)</p>	<p><b>Selected planning milestones</b></p> <p>NHS and local councils work together to set targets that will ensure more people live independently, in particular:</p> <ul style="list-style-type: none"> <li>- 1500 more intermediate care beds by 2001/02 compared to 1999/2000</li> <li>- 60,000 more people receive intermediate care services by 2001/02 compared to 1999/2000</li> </ul>
<p><b>E49</b> Assessments of older people per head of population (BV)</p>	<p><b>E49</b> Assessments of older people per head of population (BV)</p>	<p>(No targets are expected to be issued for 2001/02)</p>
<p><b>E50</b> Assessments of adults/older people leading to provision of services</p>	<p><b>Key:</b></p> <p><b>BV:</b> Best Value Indicator</p> <p><b>BVTQ:</b> Best Value indicator with top quartile target</p> <p><b>AC:</b> Audit Commission Performance Indicator</p>	<p>(No targets are expected to be issued for 2001/02)</p>

**Sources:** **1.** Performance Assessment 2000/01, A Guide. Module 4: Objectives, Indicators & Targets for Social Services (update; Oct 2000); **2.** HA Level Indicators, July 2000, NHS Executive (Excludes some NSF targets).

**Source:** Implementation Programme for the NHS Plan, Priorities Guidance (20 December 2000) **See also:** Planning for Health & Social Care (incorporating Guidance for Health & LAs on SaFFs) issued 22 December 2000.

### Service and Financial Frameworks (SaFFs)

#### Selected targets

The NSF for Older People will be implemented from April 2001. During 2001/02 it will be essential to commence implementation locally and meet all 2002 milestones.

2001/02 average rate delayed transfer (75+) is 10% (equates approx. to reduction of 1000 beds occupied by 75+ awaiting transfer of care compared with 2000/01 level.)

Average growth (between 2000/01 and 2001/02) in per capita rate of emergency admissions (75+) is less than 2%.

Rate of emergency re-admission within 28 days of discharge does not increase.

#### Selected planning milestones

NHS and local councils work together to set targets that will ensure more people live independently, in particular:

- 1500 more intermediate care beds by 2001/02 compared to 1999/2000
- 60,000 more people receive intermediate care services by 2001/02 compared to 1999/2000

(No targets are expected to be issued for 2001/02)

Standard 2 – Person-centred care		
Date	Milestone	Performance Measure
June 2001	Local arrangements for implementing the NSF are established	<ul style="list-style-type: none"> <li>Numbers/rates of people aged 75+ entering long-term institutional care (total in PAF)</li> </ul>
April 2002	The single assessment process is introduced for health and social care for older people.	<ul style="list-style-type: none"> <li>Numbers/rates of people aged 75 +in nursing and residential care (total in PAF)</li> <li>Proportion of total people aged 75 +receiving long term intensive support who are receiving this at home (total in PAF)</li> <li>Numbers/rates of people aged 75 + admitted to hospital as an emergency (SaFFR and proposed PAF indicator). We will investigate continual collections on an age-standardised basis.*</li> <li>Numbers/rates of people aged 75+ whose discharge from hospital is delayed (overall total collected by WEST and in SaFFR and proposed PAF indicator)</li> <li>Numbers/rates of people aged 75+ readmitted to hospital as an emergency within 28 days of discharge (SaFFR and proposed PAF indicator). Collection to be continued by age standardisation will be explored.</li> <li>Numbers/rates of people aged 75+ who receive an assessment under the new single assessment protocol (new measure).</li> <li>Numbers/rates of people aged 75+ in receipt of an individual care plan (new measure). Information to be collected at year end on an age-standardised basis.</li> </ul> <p>Waiting time for social services packages:</p> <ul style="list-style-type: none"> <li>For new older clients, the proportion where the time from first contact to first services is more than six weeks (version of PSS PAF PI specifically for older people), broken down by whether referral from primary/community health, secondary health or other</li> </ul> <ul style="list-style-type: none"> <li>As above, except the proportion where the time from first contact to provision or commission of all services in the care plan is more than six weeks (new measure).</li> </ul> <ul style="list-style-type: none"> <li>Numbers/rates of people aged 75+ receiving overnight respite care commissioned by SSD (RAP)</li> <li>Numbers/rates of people aged 75+ of key staff:                             <ul style="list-style-type: none"> <li>District nurses</li> <li>Health visitors</li> <li>Physiotherapists</li> <li>Occupational therapists</li> <li>Chiropodists and podiatrists</li> <li>Health care assistants</li> <li>Support workers</li> <li>Pharmacists</li> </ul> </li> </ul> <p>These cannot be broken down into the proportion of staff grades assigned to older people, but can give a general measure of access by dividing by population adjusted for age and need.</p>

Age standardisation is an alternative to employing an age cut off, by taking into account the differing age structures of the local population in the calculation of indicator values. Age standardised indicators apply to all age groups, while enabling variations to be explored in more detail to see if any particular age group is contributing most to the overall indicator.

**Standard 2 – Person centred care**

Date	Milestone	Performance Measure
April 2002	<p>All health and social care services to have reviewed the information they provide on older people's services and the formats in which it is available, and to have developed an action plan to correct any shortcomings. This should be reflected in the local Better Care, Higher Standards charter.</p>	<p>Completion monitored by RO/SCR (new measure).</p>
April 2003	<p>Systems to explore user and carer experience should be in place in hospitals in all NHS and PSS organisations. This will include regular use of the surveys to be developed within the national programme for NHS patients and carers.</p> <p>NHS organisations should have systems in place to ensure all complaints from older people, or their carers and relatives, are analysed and reported to each Board.</p> <p>HimPs and other relevant local plans should have included the development of an integrated continence service</p> <p>Systems to explore user and carer experience in PCTs should be in place.</p> <p>Single integrated community equipment services are in place</p> <p>All health and social care systems to have established an integrated continence service</p>	<p>This milestone ensures that the focus is on exploring user and carer experience. Performance measures will be developed to allow benchmarking and performance management.</p> <p>Completion monitored by RO/SCR (new measure).</p> <p>Inclusion monitored by RO (new measure)</p> <p>The milestone ensures that the focus is on exploring user and carer experience. Outcome performance measures are needed to back this up. These will be based on local survey questions which will feed into PAF indicators.</p> <p>Community equipment (which is predominantly although not entirely provided for older people):</p> <ul style="list-style-type: none"> <li>• Numbers/rates of people receiving community equipment</li> <li>• Time from first contact to completed assessment</li> <li>• Time from completed assessment to provision</li> <li>• Percentage of items of equipment costing less than £1000 delivered in less than 3 weeks [PSS indicator]</li> <li>• Percentage of items of equipment recycled by value</li> <li>• Achievement monitored by RO/SCR (new measure)</li> </ul>
April 2004		
April 2004		

Standard 3 - Intermediate care	
Date	Milestone
July 2001	Local health and social care systems to have designated a jointly appointed intermediate care co-ordinator in at least each health authority area; to have agreed the framework for patient/user and carer involvement; and to have completed the baseline mapping exercise.
January 2002	Local health and social care systems to have agreed the joint investment plan for 2002/03.

Standard 3 - Intermediate care	
Date	Milestone
March 2002	At least 1,500 additional intermediate care beds compared with the 1999/2000 baseline.
	At least 40,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline.
	At least 20,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.
March 2004	At least 5,000 additional intermediate care beds and 1700 non-residential intermediate care places compared with the 1999/2000 baseline.
	At least 150,000 additional people receiving intermediate care services which promote rehabilitation and supported discharge compared with the 1999/2000 baseline.
	At least 70,000 additional people receiving intermediate care which prevents unnecessary hospital admission compared with the 1999/2000 baseline.

**Performance Measure**

Number of people referred to non-residential intermediate care teams:

- 8103 To prevent inappropriate hospital admission
- 8104 To facilitate timely hospital discharge and/or effective rehabilitation

Number of people referred to/receiving intermediate care in a residential setting ('Rapid Response/Supported Discharge):

- 8101 To prevent inappropriate hospital admission
- 8102 To facilitate timely hospital discharge and/or effective rehabilitation

Intermediate Care Beds:

- 8157 Numbers of intermediate care beds

Expenditure on Intermediate Care:

- 8106 Total Expenditure on intermediate care (£1,000s)
- 8105 'Places' in non-residential intermediate care schemes:

Number of "places" in non-residential intermediate care schemes

Social services' support for intermediate care is indicated by:

- Households receiving intensive home care per 1000 population aged 65 or over
- Older people helped to live at home per 1000 population aged 65 or over

These are both Best Value/PSS PAF indicators.

In addition, the performance measures for Standard 2 will indicate progress on this standard.

### **Appendix 3: Partners in information management: multi-sectoral information in a primary care group area**

*Internal report\* of a project undertaken jointly by:*

The Department of General Practice and Primary Care (Queen Mary and Westfield, University of London)

The Department of Geography (Queen Mary and Westfield, University of London)

East London and the City Health Authority

The Wolfson Institute for Preventive Medicine

*In collaboration with:*

Newham Social Services

Newham Housing Department

Newham Community Health

Age Concern Newham

*Supported by a grant from the King's Fund*

The research aimed to demonstrate a partnership approach to collating and analysing data on service provision to people over the age of 75 within a single PCG area, which is also located in a Health Action Zone. The main objective was to produce a comprehensive picture of the pattern of provision to this group by different parts of the local service system (primary care, hospital care, social services, housing and the voluntary sector). The project aimed to describe and analyse the variability of service provision in a number of different ways, relating provision to population as far as possible.

The 'vision' of the project leaders was to generate co-ordinated, systematic and interpreted information about populations and services, to support policy-making in future service planning, development and evaluation for PCGs and HAZs. The information system envisaged was to use routinely collected data relating to the elderly population of the London Borough of Newham.

The general findings from the research include:

- The task of co-ordinating data across sectors is challenging, but there is considerable potential to produce integrated data by pooling expertise and different sources of routine information.
- A better understanding of variation in service provision within the PCG area can be derived by analysis of different types of unit (practices, small areas, synthesised estimates of individual service use). For example, the report contains maps showing 1997 ward level rates per 1000 people over 75 for elective admissions, emergency admissions, district nursing homes, home help hours. The reasons for the differences found are discussed. Variations in service provisions in the practice level in one PCG area are also analysed.
- Particular consideration needs to be given to ethical issues associated with sharing of data which is for individual people. The project explored the potential to estimate service use at the individual level without using personal identification codes, so as to minimise the risk of breaching confidentiality.

\*Copy of the report available from the King's Fund Programme 'Developing Rehabilitation Opportunities for Older People', photocopied by permission of the authors. Contact Daisy Hayden: Tel. 020 7307 2665, or e-mail D.Hayden@kingsfund.org.uk