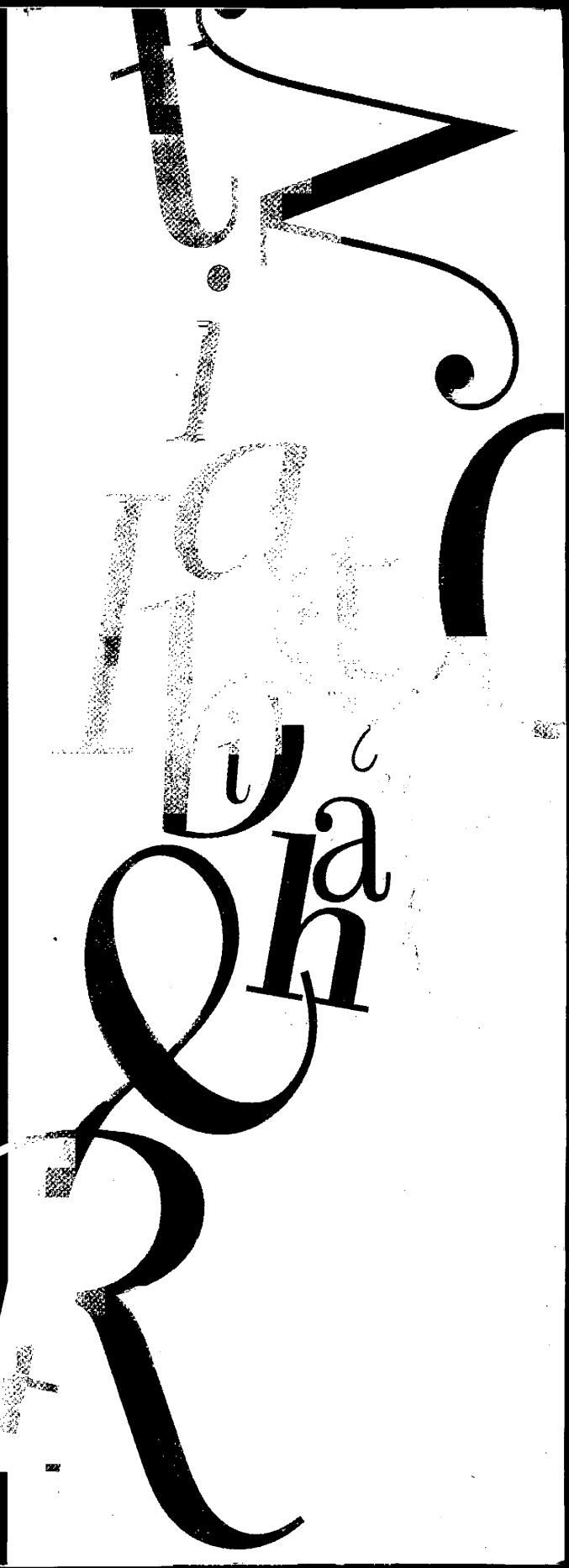
King's Fund

Investing in Rehabilitation

Janice Robinson
Stuart Turnock

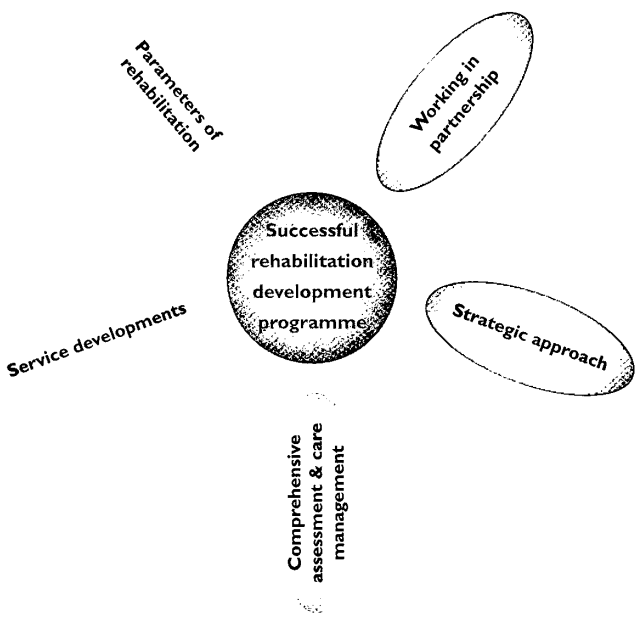


AUDIT COMMISSION
Promoting the best use of public money

King's Fund
Publishing
11–13 Cavendish Square
London W1M 0AN

This briefing paper summarises the key findings of two literature reviews jointly commissioned by the Audit Commission and the King's Fund. The reviews provide evidence of shortcomings in the current health and social care system and practices and processes that are known to be effective in achieving good outcomes for service users and for organisations that are responsible for financing or providing services.

The summary is provided to assist health and local authorities as they work together to develop better opportunities for the rehabilitation of people whose independence has been impaired by illness or injury. It presents findings on five key issues that are essential if progress is to be made.



Review findings

Setting the parameters of rehabilitation

Review findings

There is widespread confusion about the meaning of 'rehabilitation', making it difficult at times to distinguish it from other forms of care and support. Failure to clarify the aims and nature of rehabilitation inhibits focused development activity.

To make progress, authorities will need to consider what they mean by 'rehabilitation' so that they are clear about what they want to commission, how it will be contracted and how provision will be monitored and evaluated.

Working in partnership

Review findings

Successful rehabilitation usually involves a mixture of clinical, therapeutic, social and environmental interventions that are not the preserve of any one agency. Both the NHS and local authorities have an interest in improving opportunities for rehabilitation. Both are experiencing financial pressures associated with rising demands for acute and long-term care. Rehabilitation could offer an alternative to expenditure on unnecessary hospital stays, care home placements or complex care packages.

To make progress, authorities will need to work together to develop rehabilitation. Collaboration is required for planning at strategic and locality levels. Arrangements also need to be put in place for joint working between health and social care practitioners as they assess individual need and co-ordinate the implementation of rehabilitation care plans. Priorities should be agreed for the deployment of specialist staff and for the education and training of a wide range of health and social care practitioners.

Developing a strategic approach

Review findings

There has been a decline in rehabilitation over the last decade. Shortfalls appear to be affecting people with long-term illness or disability disproportionately, with older people experiencing particular disadvantage. Provision outside hospital settings continues to be under-developed.

To make progress, authorities will need a coherent joint strategy (linked to Joint Investment Plans) to reshape current services and ensure improved outcomes that are sustainable in the medium and long term. These strategies will need to support developments in primary and community care settings and to target groups of people known to have restricted access to rehabilitation. They will need to be built around the knowledge base on effectiveness and good practice.

Implementing comprehensive assessment and care management

Review findings

There is strong evidence that comprehensive assessment, followed by the implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in care homes, improves their survival rates and improves physical and cognitive functioning. Such assessment ensures that treatable conditions such as depression and incontinence are recognised and dealt with and that suitable arrangements are made to enable a return to independent living.

To make progress, authorities need to recognise that comprehensive assessment is a critically important determinant of successful rehabilitation. Authorities will need to co-operate in putting in place arrangements which enable the assessment of individuals' medical, social, psychosocial, functional and environmental needs. This will involve contributions from a range of professionals.

Piloting service developments

Review findings

Innovative approaches to rehabilitation are being tried out in people's homes, special short-stay units and hospital wards, but evidence of their effectiveness is only just beginning to emerge. Greater emphasis on research and evaluation is needed. The scope for developing a rehabilitative culture in domiciliary, day and residential services is beginning to be recognised but as yet barely put into practice. Services need to concentrate upon the needs of older people for rehabilitation.

To make progress, authorities will need to support innovation and experiment in rehabilitation, testing out different ways of integrating rehabilitative goals into the overall service system. New schemes and initiatives will need to be evaluated. The research community has a role to play in ensuring that the evidence base is further developed and improved. Service developments will especially need to concentrate on the needs of older people for rehabilitation.

Developing rehabilitation

The case for change

There is a widespread recognition of the urgent need to invest in rehabilitation. This policy imperative is evident in the 1997/8 *Priorities and Planning Guidance for the NHS*[1] and in the recently issued Executive Letter[2] in which the Secretary of State for Health made it clear that he expected all health and local authorities to be purposively developing rehabilitation services as one of three priorities in joint work undertaken for people with continuing health care needs.

Recognition of problems regarding the adequacy of rehabilitation services has been building up over the last decade. Concern that the NHS had been withdrawing from this aspect of care intensified in the period following the implementation of the NHS and Community Care reforms, culminating in the Department of Health's guidance on continuing care.[3] This guidance reaffirmed NHS responsibilities for a range of provision, including rehabilitation. Extra resources were subsequently made available (£16 million in 1996/97 and £20 million in 1997/98) through a Challenge Fund set up to finance continuing-care service developments, including those relating to rehabilitation. These special funds were made available on the understanding that health authorities would match the funding from their current resources. While this injection of extra resources was appreciated, there was nevertheless a recognition at central and local levels that, in the longer term, developments in rehabilitation would have to be rooted in mainstream budgets, service configurations and professional practice, rather than in special one-off schemes.

Investment in rehabilitation emerged yet again in October 1997, when the new Labour Government announced an extra £300 million for the NHS to help deal with increased demand during the winter months. Hopes were expressed at the time that some of this extra cash might be used to fund community services aiding the rehabilitation and recuperation of older people, thus relieving pressure on acute hospital beds.

Other agencies have been highlighting problems arising in the area of continuing care and drawing attention to failings in rehabilitation provision. The Audit Commission's study on the care of people with fractured neck of femur[4] found that the NHS was failing to put systems in place to co-ordinate care following surgery and to maximise patients' chances of rehabilitation and recovery. A subsequent study, *The Coming of Age*,[5] drew attention to shortcomings in the way health and social services have been working together to address the needs of older people and pointed to the need to improve procedures and develop services that would offer alternatives to unnecessary admission to hospital or to residential care and nursing homes.

In 1996, the King's Fund mounted an investigation into rehabilitation, looking first at the experiences and perceptions of users, carers, practitioners and managers. The report of those consultations revealed widespread disquiet about the current state of affairs and enthusiastic support for a nation-wide development programme designed to increase and improve opportunities for rehabilitation.[6] A second line of inquiry, undertaken in co-operation with the Audit Commission, involved two literature reviews, one examining policy trends[7] and the other looking at evidence of effective practice in rehabilitation.[8]

These reviews were commissioned originally to help shape and focus future development programmes of the Audit Commission and the King's Fund. They were subsequently published and made available to a wider audience. The first of these reviews found evidence of deterioration in services promoting rehabilitation on both sides of the health and social care divide, with older people experiencing particular disadvantage. The second review considered studies concerning the organisation and delivery of rehabilitation services and recommended that steps should be taken to implement proven good practice more widely.

Taken together, these different studies make a strong case for change. Current arrangements in health and social services are leading to unnecessary dependence and misery among service users, most especially among older people, who appear to be especially disadvantaged.

Services promoting rehabilitation have been squeezed by pressures related to acute and long-term care, leaving few alternatives to more frequent or

longer stays in hospital, entry to residential care and nursing homes or complex packages of support at home. The result is a distorted system of care, spiralling expenditure and inefficient use of scarce resources – what the Audit Commission has termed 'a vicious circle'.

Time to invest in rehabilitation

These same studies indicate what needs to be done to improve the current situation. Agencies need to invest in rehabilitation. On one level, this will mean investing time and effort in collaborative commissioning, in multi-disciplinary assessment and care management systems and in the teamwork needed to enable individuals to make the transition towards greater independence following illness or injury. On another level, it will mean investing in new service developments.

The agenda faced by authorities is a complex and daunting one – in the context of resource constraints. The two published literature reviews were commissioned to help us understand how progress might best be made. In many respects they throw up as many questions as answers – questions that both agencies will go on to explore in their respective work programmes. However, the reviews also highlight issues that authorities need to consider now if progress is to be made. We concentrate here on summarising those findings.

Setting the parameters of rehabilitation

Review findings

There is widespread confusion about the meaning of rehabilitation, making it difficult at times to distinguish it from other forms of care and support. Failure to clarify the aims and nature of rehabilitation inhibits focused development activity.

The origins of rehabilitation lie in a number of separate developments since World War I, and these roots are evident in the continuing debate about its nature. The concept of rehabilitation has since been applied within an increasing number of medical specialties – although the priority given to it varies, especially compared to curative treatment. It has increasingly been provided in a variety of settings – hospital, 'outreach' and community. There is a continuing debate between calls for specialist services to be available for patients, and the view that rehabilitation skills should be available as an integral part of mainstream services.

The term 'rehabilitation' has many meanings and interpretations. Problems can arise when it is defined so broadly that it becomes difficult to distinguish it from other aspects of care, such as prevention, treatment or maintenance. This inhibits progress. It is useful to distinguish rehabilitation from other aspects of care by focusing on its goal or overall aim. The key aim is to enable the individual concerned to regain as far as is possible independence that has been impaired by illness or injury. This involves a range of interventions designed to restore to the optimum level possible physical or mental capabilities, as well as opportunities to resume social roles that are important to the individual concerned.

Increasingly, it is recognised that rehabilitation has to be 'holistic' – incorporating medical, social and environmental support. The growing emphasis on user involvement has had its impact too, with many practitioners acknowledging the need for service users to play an active part, for example, in setting the goals for their own rehabilitation.

In reviewing the concept of rehabilitation, there is a growing consensus that the following factors contribute to effective rehabilitation:

- responsiveness to users' needs and wishes
- multi-disciplinary and inter-agency working
- availability when required
- clear rehabilitative purpose and goals.

Finally, it is clear that rehabilitation is often a function of services, but not necessarily a service in its own right. Where it is an implicit activity, it is important to acknowledge that it is taking place.

***To make progress*, authorities will need to consider what they mean by 'rehabilitation' so that they are clear what they want to commission, how it will be contracted and how provision will be monitored and evaluated.**

Working in partnership

Review findings

Successful rehabilitation usually involves a mixture of clinical, therapeutic, social and environmental interventions that are not the preserve of any one agency. Both the NHS and local authorities have an interest in improving opportunities for rehabilitation. Both are experiencing financial pressures associated with rising demands for acute and long-term care. Rehabilitation could offer an alternative to expenditure on unnecessary hospital stays, care home placements or complex care packages.

People who have lost some degree of independence through the effects of disease or accident have a mix of health and social care needs. It is often impossible to separate those needs, particularly among those who have a long-term illness or complex disabilities. Both health and social care agencies have an interest in improved rehabilitation outcomes – through maximising independence and limiting dependence on expensive service options.

Reviews show that the organisation of complex interventions may be highly relevant to effective rehabilitation; 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.

Future development will require a greater emphasis on training and education in rehabilitation. Since the operation of teams is seen as an important prerequisite for effective rehabilitation, consideration needs to be given to the issue of multi-disciplinary team development and maintenance in day-to-day practice.

***To make progress*, authorities will need to work together to develop rehabilitation. Collaboration is required for planning at strategic and local levels. Arrangements also need to be put in place for joint working between health and social care practitioners as they assess individual need and co-ordinate the implementation of rehabilitation care plans. Priorities should be agreed for the deployment of specialist staff and for the education and training of a wide range of health and social care practitioners.**

Developing a strategic approach

Review findings

There has been a decline in rehabilitation opportunities over the last decade. Shortfalls appear to be affecting people with long-term illness or disability disproportionately, with older people experiencing particular disadvantage. Provision outside hospital settings continues to be under-developed.

There are indications of a decline in the opportunities for rehabilitation over the past decade, despite increases in the numbers of specialist staff (e.g. in rehabilitation medicine and professions allied to medicine). Deficits are also evident in some settings (e.g. the community); in its distribution, leading to gaps in certain parts of the country; and for certain conditions/disease states (e.g. back pain, arthritis, head injuries and stroke). Moreover, most rehabilitation services are provided by the health service in hospital settings. The potential of other settings (e.g. primary and community) is under-developed. And, while rehabilitation is an explicit element in some social care services and implicit in others, social services authorities have not fully recognised the role they could potentially play.

Particular concerns have been raised about the lack of sufficient services for older people – with a marginalisation of rehabilitation in acute hospitals, a reduction in long-stay geriatric beds, and a lack of compensatory rehabilitation services in the community.

The respective responsibilities of health and social care authorities for rehabilitation are often disputed: a joint approach offers one way of resolving such disputes, as well as providing a more appropriate service for users. This requires a locally derived joint strategic approach drawing on all available information about organisational arrangements and therapeutic practices that have been shown to produce good outcomes.

There is a body of knowledge about good practice that is more substantial than is commonly believed to be the case. There is strong evidence, for example, that comprehensive geriatric assessment is

associated with reduced rates of mortality and institutionalisation and with improved functional outcomes. Multi-disciplinary stroke teams also produce good outcomes, and there are significant positive results in the area of cardiac rehabilitation. Family therapy is associated with favourable outcomes for people with schizophrenia, and educational approaches have been found to be effective in the rehabilitation of people with diabetes and chronic airways disease and heart disease.

There is an absence of evidence from systematic reviews regarding social care interventions, but there are encouraging indications from evaluative studies in progress that short therapeutic programmes based in residential units[9] can be effective in helping older people to regain their confidence after an acute episode and to return to independent living with minimal support at home.

***To make progress*, authorities will need a coherent joint strategy (linked to Joint Investment Plans) to reshape current services and ensure improved outcomes that are sustainable in the medium and longer term. These strategies will need to support developments in primary and community care settings and to target groups of people known to have restricted access to rehabilitation. They will need to be built around the knowledge base on effectiveness and good practice.**

Implementing comprehensive assessment and care management

Review findings

There is strong evidence that comprehensive assessment, followed by the implementation of individual care plans, reduces the risk of older people being re-admitted to hospitals or placed in care homes, improves their survival rates and improves physical and cognitive functioning. Such assessment ensures that treatable conditions such as depression and incontinence are recognised and dealt with and that suitable arrangements are made to enable a return to independent living.

The results of the systematic review of comprehensive geriatric assessment indicate major benefits in a variety of settings. Since assessment is a key stage of rehabilitation, upon which is based subsequent management, the significance of this cannot be underestimated. If the effects of comprehensive geriatric assessment are considered, they show a 35 per cent reduction in death rate and a 12 per cent reduction in subsequent admissions to hospital. Effects of this magnitude are greater than those seen for many accepted drug treatments.

This points toward the importance of considering the different phases of the rehabilitation process and the role of assessment in recognising the need for and organising a complex approach to care.

***To make progress*, authorities need to recognise that comprehensive assessment is a critically important determinant of successful rehabilitation. Authorities will need to co-operate in putting in place arrangements which enable the assessment of individuals' medical, social, psychosocial, functional and environmental needs. This will involve contributions from a range of professionals.**

Piloting service developments

Review findings

Innovative approaches to rehabilitation are being tried out in people's homes, special short-stay units and hospital wards, but evidence of their effectiveness is only just beginning to emerge. Greater emphasis on research and evaluation is needed. The scope for developing a rehabilitative culture in domiciliary, day and residential services is beginning to be recognised but as yet barely put into practice. Services need to concentrate upon the needs of older people for rehabilitation.

Rehabilitation practice and contracting need to be evidence-based. Future developments in rehabilitation in services should be evaluated, perhaps using clinical audit, in order to promote quality improvement in care.

The evidence base needs to be further developed and improved, placing particular emphasis on the experiences of and outcomes for users as well as cost-effectiveness.

The rehabilitative goals of social care services (domiciliary, day and residential) need to be fully recognised and clarified to expand opportunities in the community. Both health and social services need to concentrate upon the needs of their local population, especially older people, for rehabilitation. The major need for rehabilitation lies among older people, as does the greatest potential benefit.

***To make progress*, authorities will need to support innovation and experiment in rehabilitation, testing out different ways of integrating rehabilitative goals into the overall service system. New schemes and initiatives will need to be evaluated. The research community has a role to play in ensuring that the evidence base is further developed and improved. Service developments will especially need to concentrate upon the needs of older people for rehabilitation.**

Conclusion

This briefing paper summarises key information that is covered in greater detail in two literature reviews examining rehabilitation policy and practice.[7,8]

The task facing health and local authorities is large, but so is the potential benefit. As the review on practice notes, a 'new clear focus on rehabilitation with greater clarity of definition, purpose and role could capitalise on the knowledge base, galvanise the present forces for change, provoke a more coherent research effort and improve service delivery'.

Future work of the Audit Commission and King's Fund

As health and social care bodies create and implement joint rehabilitation strategies, the Audit Commission and the King's Fund will be reviewing progress, offering support and constructive feedback on service performance. In 1998, the Audit Commission will be carrying out a study looking at the ways in which health and local authorities are providing opportunities for rehabilitation and commenting on the progress being made. At the same time, the King's Fund plans to establish a development programme, creating a network for local health and social care agencies to share information about innovation and good practice in the rehabilitation of older people and providing support to selected authorities as they develop joint rehabilitation development strategies and implement arrangements for comprehensive assessment and care management. Further information about these programmes of work will be made available by both organisations.

References

1. Department of Health. *Priorities and Planning Guidance for the NHS: 1997/98*. NHS Executive, June 1996.
2. Department of Health. Executive Letter EL(97)62. *Better Services for Vulnerable People*. October 1997.
3. Department of Health. *NHS Responsibilities for Meeting Continuing Health Care Needs*. Health Service Guidance HSG(95)8/LAC(95)5: Department of Health
4. Audit Commission. *United They Stand: Co-ordinating care for elderly patients with hip fracture*. London: Audit Commission, 1996.
5. Audit Commission. *Coming of Age*. London: Audit Commission, 1997.
6. Robinson J, Batstone G. *Rehabilitation – the development agenda*. London: King's Fund, 1996.
7. Nocon A, Baldwin S. *Trends in Rehabilitation Policy – a literature review*. London: King's Fund, 1998.
8. Dickinson E, Sinclair A. *Effective Practice in Rehabilitation – reviewing the evidence*. London: King's Fund, 1998.
9. Younger-Ross S, Lomax T. *Outlands: Five Years On*. To be published in Community Care Management: Vol 6. Issue 1, Feb 1998.