

Achieving independence for older people through rehabilitation/intermediate care - New data collection

1. This paper sets out the details of collecting new information to support the indicator on 'Achieving independence for older people through rehabilitation/intermediate care' within the Department of Health Vital Signs and National Local Government Indicator set. The detailed definition of the indicator as set out in the NIS PI definitions set issued in February 2008 with some minor amendments is attached in Annex B.

Proposed data collection

2. The Strategic Information Group on Adult Social Care (SIGASC) agreed to collect the required data through the Key Statistics (KS1) return with data being reported locally to the CASSR and local PCTs three months in arrears for each quarter. The aggregated data for six months of the calendar year's discharges (**1 July to 31 December**) would form the basis of the annual return to the Information Centre for health and social care by May 31st of the ensuing year.
3. The information is to be collected to allow the numerator and denominator to be broken down by age and gender to provide more information to address the equalities agenda as shown in the table in Annex A. This would also add greater understanding of the coverage of joint rehabilitative work locally. There are likely to be significant differences in the success of rehabilitation between age and gender groups.

Timing of implementation for 2008/09

4. It was agreed that this collection would be subject to a pilot with a few councils this winter to check that the definitions etc are workable and then implement it, with any necessary modifications/ clarifications arising from the pilot, for all discharges from hospital where, on the basis of a joint multidisciplinary assessment, a 'rehabilitation/re-enablement service' is provided which includes input from the CASSR and/or PCT during the period **1st October 2008 to 31st December 2008** with a 3 month follow-up.
5. For the first year of collection in 2008/09 councils with large numbers of discharges to rehabilitation/re-enablement services will have the option of doing a random sample across the 3 month period (similar to the sampling for RAP A8 for PAF AO/D56). Detailed sampling guidance will be sent out in due course. The data collection covers both residential and non-residential 'rehabilitation/re-enablement services'.
6. Although for 2008/09 we are starting with a narrow scope, it does not mean we are ignoring step up rehabilitation efforts where hospitalisation is avoided. This may be developed later as a fuller version of this measure.

Rationale for the PI

7. The NSF on older people (May 2001) seeks to improve the effectiveness of health and social care outcomes for older people. One focus is to reduce delayed discharge from hospital and ensure effective rehabilitation for those discharged so that they can regain their independence at home (see Standard 3 pages 41-50: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066)

8. This PI seeks to establish for older people discharged from hospitals whether inputs by CASSRs and/or the NHS following a joint rehabilitation plan achieve the goals agreed between the CASSR's staff and health practitioners. The intention of the joint care plan must be that the older person should return home (directly or via a stay in a care home).

9. The definition of the numerator and denominator for the indicator is as follows;

Numerator = Number of those people discharged and benefiting from intermediate care/rehabilitation/re-enablement still living at home (including in extra care housing or an adult placement scheme setting) three months after discharge from hospital.

Note:

At the 3 month point those temporarily in hospital or in a care home for respite/ short term care with a clear plan for their return home at the three month point should be counted as being still 'at home'.

Denominator = Number of people discharged from hospital aged 65 and over on discharge date where, following discharge, one or more services commissioned by health and/or social care were provided to achieve rehabilitation/re-enablement.

Note:

At the 3 month date those who had on discharge been expected to return home who;

(i) Are in hospital (other than for a brief episode of care from which they are expected to return home) or

(ii) are in a registered care home (other than for a brief period of respite care from which they are expected to return home) or

(iii) have died

should be included in the denominator but not reported in the numerator.

(iv) Patients who had been admitted to hospital from a care home and were discharged to a care home with no plan to return to living in the community are excluded from the indicator.

(v) Patients discharged to a care home or to a hospital setting where there was no expectation of their returning to living in the community are also excluded from the indicator.

Pilot

Following discussion at the Strategic Information Group on Adult Social Care (SIGASC), Adult Review Group (ARG) and a subgroup of the Southwest regional ADASS group, the table and definitions were developed.

The IC recently ran a pilot by asking councils to record information relating to all discharges into joint rehabilitation services during September 2007 and to follow them up as much as possible 3 months (91 days) after discharge. As part of this pilot, councils were trying out different methods to trace all the people who have been discharged. Some initial suggestions were as follows;

- social care records
- patient registrations from Primary Care Trusts
- address details from GPs
- benefits data from housing team
- details of deaths from local Registrars
- details from local National Health Application and Infrastructure Services (NHAIS) use of the NHS Strategic Tracing Service (<http://www.connectingforhealth.nhs.uk/systemsandservices/nsts/access>)

The pilot councils identified the need to notify those patients being discharged with planned rehabilitation services that they may be contacted by post after 3 months to establish their whereabouts (and possibly whether they were happy with the outcome of the rehabilitation services).

It may also be helpful for councils and PCTs to agree at the time of the assessment who will take the lead in following up the patient 3 months later which may depend on the type of rehabilitation/re-enablement services which are to be provided.

A summary of the results from the pilot are presented in paper SIGASC 08/1/3a at the meeting on 17th March 2008 and are available from the weblink below.

<http://www.ic.nhs.uk/our-services/improving-social-care-information/review-approval-and-development/sigasc>

A revised version of the proposed table and guidance are attached in Annex A.

**Information Centre for health and social care
May 2008**

Achieving independence through rehabilitation

Proposed table for data collection

	65-74		75-84		85 and over		Total		Overall total
	M	F	M	F	M	F	M	F	
Number of discharges in denominator where person was still at home 91 days later (Numerator)									
Number of discharges to rehabilitation where the intention is for the patient to go back home (Denominator)									
% of those discharged still at home 91 days later									
Number of discharges to rehabilitation in care home settings where there is no expectation for the patient to return home ¹ for:									
a) patients newly admitted to care homes									
b) patients readmitted to care homes									
Number of discharges where person was not known to social services 91 days after discharge and required following up by social services									
Number of discharges where person could not be traced after 91 days									
Number of discharges where person was still receiving rehabilitation services at 91 days (if so, please provide more details in box below)									

Comments:

1. These discharges will not be included in rows 1-3, and there is no expectation that these cases will be followed up. This information will be used to provide a broader picture of rehabilitation//re-enablement services outside of hospitals and contextual information to understand differences across councils. Information from other sources like Hospital Episode Statistics (HES) on discharges and Supported Residents (SR1) data on permanent admissions to care homes will also be used to provide additional information to support this collection.

Reporting period:

2008/09 – 1 Oct 2008 - 31 Dec 2008

2009/10 – 1 Jul 2009 – 31 Dec 2009

Definitions

Rehabilitation/re-enablement services

A rehabilitation/re-enablement service is provided for people on discharge from hospital who;

1. Would otherwise face an unnecessarily prolonged stay in acute in-patient / community hospital care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS in-patient care;
2. Have a planned outcome of maximising independence and enabling them to resume living at home;
3. Are provided with care services on the basis of a joint multi-disciplinary assessment resulting in an individual support plan that involves active therapy, treatment or opportunity for recovery;
4. Are to receive short-term rehabilitative interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less.

Therefore, on the basis of a joint, multi-disciplinary assessment prior to their hospital discharge, the patient will subsequently have received services specifically aimed at rehabilitation/re-enablement and the patient's return to living at home. It requires inputs commissioned/provided by the NHS and/or the CASSR to re-enable or rehabilitate the patient so that they can continue to live at home, with or without the ongoing need for support by formal care staff.

Rehabilitation/re-enablement should not solely comprise of the provision of, for example, an item of equipment, wound nursing or provision of meals on wheels or getting up / putting to bed services, nor simply restarting of service(s) already in place at the time of admission to hospital

unless the service(s) were specifically intended to provide rehabilitative//re-enablement support.

The data collection covers both residential and non-residential 'rehabilitation/re-enablement services'.

Discharges

A hospital discharge is defined as an individual who has been formally admitted to hospital (not simply an attendance at A and E or outpatients) and then discharged. The length of time between admission and discharge will vary from a few hours (e.g. in a clinical decision unit) to days or weeks.

This table is based on the total number of discharges with a rehabilitation/re-enablement plan agreed jointly by the NHS and CASSR where the objective is to see the patient return home within the reporting period, not the unique number of people who have been discharged who meet these criteria over the period.

Double counting

If an individual has had more than one discharge to rehabilitation/re-enablement services during the reporting period, then include each discharge.

Age group

Age is calculated as at the date of discharge.

Start date

This is the date the joint rehabilitation services started, therefore the first day is recorded as day 1, not day 0.

Measuring time

3 months is measured as 91 days based on calendar days, not working days.

Type of hospital

Discharges of those aged 65 and over from both acute and community hospitals should be included (discharges from psychiatric units and EMI units should be excluded). Councils and NHS partners may, however want to extend the local reporting process to cover these discharges and / or instances where a joint rehabilitation plan is arranged to avoid admission to hospital.

The start date will be the day the discharge from the last hospital in the sequence of placements in hospitals ends. Some examples are;

(i) a person may be first admitted to an acute bed, then transferred to a community hospital bed, and then discharged to rehabilitation/re-enablement service in a care home. The start date will be the day the person is discharged to rehabilitation/re-enablement service in a care home.

(ii) a person may be first admitted to an acute bed, then transferred to a community hospital bed, sent back for final checks in an acute bed and then discharged to rehabilitation/re-enablement service. The start date will be the

day the person is discharged to rehabilitation/re-enablement service.

Multi-disciplinary assessment

This is defined as where both the health and social care needs of the individual have been assessed. This assessment may have been done jointly by health and social care staff, social care staff only or health staff only. The key element is that both the health and social care needs of the individual have been assessed.

Living at home

This is defined as those people living in their own home in the community, including in extra care housing or an adult placement scheme setting. Those people who are in hospital (other than for a brief episode of care from which they are expected to return home) or are in a registered care home (other than for a brief period of respite care from which they are expected to return home) are not considered to be living at home.

Person not known to social services and requiring following up

These are discharges where social services have no details of the person 91 days after discharge, e.g. the person is not listed on the social care records or on the books to receive social care services. In these cases social services have to use a variety of methods to trace these cases, for example via PCTs or GPs (see suggestions on page 3).

When the person cannot be traced

For discharges where the person cannot be traced after 91 days, they should be included in the denominator, but not in the numerator. The number of discharges where the person cannot be traced should be recorded in the seventh row of the table.

Exclusions

The following situations are **excluded** from the table;

- rehabilitation/re-enablement services which are provided solely by social services with no involvement of any health practitioner in the assessment / care planning process
- Rehabilitation/re-enablement services following hospital discharge which are provided solely by health with no joint consideration of needs in the assessment/care planning process. (PCTs may wish to collate evidence on such activity and its outcomes for local consideration)
- continuing care services provided solely by health
- palliative care

Annex B

Is data provided by the LA or Local Strategic Partner?	Is this an existing indicator?
Y	N
NI 125: Achieving independence for older people through rehabilitation / intermediate care	
Rationale	<p>This indicator measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode. It captures the joint work of social services and health staff and services commissioned by joint teams. The measure is designed to follow the individual and not differentiate between social care and NHS funding boundaries. The measure covers older people aged 65+ on discharge from hospital who:</p> <ol style="list-style-type: none"> 5. Would otherwise face an unnecessarily prolonged stay in acute in-patient care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS in-patient care; 6. Have a planned outcome of maximising independence and enabling them to resume living at home; 7. Are provided with care services on the basis of a multi-disciplinary assessment resulting in an individual support plan that involves active therapy, treatment or opportunity for recovery (with contributions from both health and social care); 8. Are to receive short-term interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less. <p>This new indicator relies on new data which will require piloting and is not likely to be available for reporting until October 2008. Comments from the consultation process will be taken into consideration as part of the development and piloting process.</p>
Definition	<p>The proportion of older people discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on / back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital.</p> <p>Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator.</p> <p>3 months is defined as 91 days.</p> <p>Details of the timeframe for the numerator and denominator are being discussed as part of the development of the new collection. The aim is to finalise the details of this new collection by the end of March 2008</p>

Formula	$\left(\frac{X}{Y}\right) * 100$ <p>Where: X = Number of those people discharged and benefiting from intermediate care / rehabilitation still living at home (including in extra care housing or an adult placement scheme setting) three months after discharge from hospital. (Those temporarily in hospital or in a care home for respite/ short term care with a clear plan for their return home at the 3 month point should be counted as being still 'at home'. Those who have died within the three months are not reported in the numerator). Y = Number of people discharged from hospital aged 65+ on discharge date entering joint 'intermediate care' or a 'rehabilitation service' which includes input from the CASSR in the period (including those who are in hospital or in a registered care home at the three month date and those who have died within the three months).</p>		
Worked example	<p>Suppose the number of people aged 65+ on discharge and who were discharged and benefited from intermediate care/ rehabilitation still living at home 3 months after discharge in 2006 = 2,848.</p> <p>And if the total number people discharged from hospital aged 65+ and entering into joint 'intermediate care' or a 'rehabilitation service' for 2006 = 4,297</p> <p>Therefore the percentage achieving independence = $(2848/4297) * 100$ = 66.3%</p>	Good performance	<p>Good performance is typified by a higher percentage.</p>
Collection interval	Annual – exact details are being worked up as part of the development work	Data Source	Social Care Keystats Collection (KS1) (Collection still being developed)
Return Format	Percentage	Decimal Places	One
Reporting organisation	Information Centre Health and Social Care derived from information supplied by Councils with Social Services Responsibilities		
Spatial level	Single tier and county council		
Further Guidance	Information Centre for health and social care: http://www.ic.nhs.uk/our-services/improving-social-care-information/social-care-collections		