REHAB ON TRACK

Community Rehabilitation Best Practice Standards

Scotland

March 2024

These standards outline key responsibilities and measures for all those delivering, planning, providing and participating in rehabilitation. They are applicable to all clinical conditions including multimorbidity and across all settings and sectors.

Published by The Chartered Society of Physiotherapy on behalf of the Right To Rehab Coalition

Contents

Introduction

The right to habilitation and rehabilitation is set out in Article 26 of the UN Convention on the Rights of Disabled People (CRPD) to enable independent living and full inclusion and participation in all aspects of life.[1] Rehabilitation has also been set as a World Health Organization priority for global health systems, recognizing the profound unmet need for rehabilitation worldwide and the importance of strengthening health systems to provide rehabilitation.[2]

Scotland's population is ageing, with the proportion of people of pensionable age projected to rise from 18 % in 2018 to 23 % by 2043, with the number of people aged 90 or over projected to double. Health inequalities have also increased with the life expectancy in the most deprived 40 % of areas decreasing and an increase in the number of years people are living in ill health. According to Public Health Scotland, the burden of disease[3] in Scotland is forecast to increase by 21 % by 2043.An outcome of these factors would be an increasing demand on health and social care services, and a change in the burden of disease towards increasing prevalence of long term and neuro-degenerative conditions.[4]

The needs of many people who require community rehabilitation are not met. There is widespread unwarranted variation in the provision and quality of rehabilitation which has been worsened by the Covid19 pandemic. Without access to high quality, community-based rehabilitation, people will continue to be driven towards the most expensive parts of the health and social care system, such as A&E and secondary care.

There remains a need for robust and measurable quality standards in community rehabilitation to support implementation with a clear link to Scotland's health and social care standards . These standards are required to drive quality improvement and consistency across all sectors and settings in health and social care, to be used by everyone involved in planning, delivering and/or receiving community rehabilitation services. Ultimately, rehabilitation services which function to this standard will lead to better health outcomes for the entire population of Scotland.

The Expert Reference Group for the following standards was drawn from UK representatives from a broad range of disciplines, working in a variety of settings, academic expertise and wide user representation, through the third sector service user organisations and charities.

A campaign for the 'right to rehabilitation' exists across the UK. The Community Rehabilitation UK Standards Guidance 2022 (presented here in the Scotland edition), have been approved by the Right to Rehab Coalition in Scotland, and its sister organisations, the

Introduction (continued)

Community Rehabilitation Alliance England, the Community Rehabilitation Alliance Northern Ireland and the Right to Rehab Campaign in Wales.

The Right to Rehab Coalition in Scotland was formed in 2019 as a collective of health charities and professional bodies who are committed to delivering the Right to Rehab in Scotland. Current members of the Coalition are:

- Alzheimer Scotland
- Asthma UK
- British and Irish Orthoptic Society
- British Association of Prosthetists and Orthotists
- British Dietetic Association
- British Lung Foundation Scotland
- Cerebral Palsy Scotland
- Chartered Society of Physiotherapy
- Chest, Heart and Stroke Scotland
- College of Podiatry
- Health and Social Care Alliance Scotland (the ALLIANCE)
- MS Society Scotland
- Parkinson's UK
- Revive MS Support
- Royal College of Occupational Therapists
- Royal College of Speech and Language Therapist
- Sight Scotland
- Stroke Association
- Sue Ryder

Rehabilitation and Recovery – Once for Scotland, a person-centred approach to rehabilitation in the post covid era sets out a modern framework for rehabilitation based on a personalised, preventative, and integrated approach to health and social care, that takes account of social, physical, psychological and mental health needs. It builds on the strong commitment made by Scottish Government in June 2022 to make a right to rehabilitation a reality. Covid has reinforced the message that we must do things differently. Traditional models of rehabilitation and workforce configuration based on a single condition and/or diagnosis are no longer appropriate, given the current context of an ageing population with increasingly complex physical and psychological needs, including multiple long-term conditions (LTCs). Good rehabilitation is essential to enable people to live well with long-term conditions.

Rehabilitation and Recovery – Once for Scotland sets out 6 principles for good rehabilitation:

1. Easy to access for every individual
2. Provided at the right time
3. Realistic and meaningful to the individual
4. Integrated
5. Innovative and ambitious
6. Delivered by a flexible and skilled workforce

1 www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-26-habilitation-and-rehabilitation.html

2 www.who.int/initiatives/rehabilitation-2030

3 Burden of Disease overview – Impact of ill health – Health inequalities – Public Health Scotland

4 www.gov.scot/publications/scotland-future-opportunities-challenges-scotlands-changing-population/pages/6/

5 Supporting documents – Health and Social Care Standards: my support, my life – gov.scot (www.gov.scot)

Purpose

This guidance provides a number of recommendations and standards which have been systematically developed to guide the development, delivery and monitoring of high-quality person centred rehabilitation across the UK. The scope of the guidance is for all of the UK, and this is reflected in the methodology for its development. It provides a basis from which community rehabilitation services can deliver high-quality person-centred evidence-based rehabilitation and seek to decrease both local and national variation. This version has been adapted to reflect the Scottish context.

These recommendations and standards apply to adult community rehabilitation services and will improve individual and population-based health and well-being. This document takes a rights based, person-centred, needs led approach rather than by diagnosis and/or condition approach and aims to:

- Lead to clearer pathways for disabled people and those with long term conditions
- Enable supported self-management and goal setting
- Streamline pathways by facilitating early supported discharge from hospitals and preventing avoidable re-admission
- Ensure care delivery within people's own homes and communities wherever possible
- Realise people's human rights including, but not exclusively, their right to health and right to independent living

The audiences for this guidance include:

- Adults who access or may need to access community rehabilitation services
- Families and carers of community service users

Purpose (continued)

— Clinicians and managers delivering community rehabilitation
— Policymakers, planners and providers of community rehabilitation services.
— Rehabilitation Leads on Health Boards and Integrated Joint Boards
— Rehabilitation networks, including organisations in the third and leisure sector who provide rehabilitation services

This document uses the terms ‘clinician’, ‘rehabilitation lead’ and ‘planner’ to describe the people in health and care services involved in creating and delivering community rehabilitation services.

This document uses the word ‘people’ to describe people using community rehabilitation services to address their needs and achieve outcomes that matter to them. The use of the biopsychosocial model ensures that clinicians respect people as individuals. It is expected that:

— A person’s family will always be made welcome, and be involved, provided this is what the person wants.
— Information sharing with wider family is only undertaken with the person’s explicit consent.
— Information is provided in formats that are accessible to people with sensory, cognitive and communication difficulties including those with English as a Second Language (ESL).
— Everyone is aware of the diverse social and cultural needs of their local population.
— Everyone is aware of their responsibilities to underserved populations and take steps to minimise health inequalities

Definition of Community Rehabilitation

For the purposes of this guidance, community rehabilitation is defined as all rehabilitation and supported self-management delivered to a person in any setting outside a hospital. This description includes all rehabilitation delivered across all sectors and care homes. It is provided by the wider workforce upskilled in delivering on the principles and practices of generic, non-specialist rehabilitation as well as multidisciplinary teams including specialist Allied Health professionals, to optimise function, social participation and improve health and wellbeing and includes:

- Initial collaborative, outcomes focused and strengths-based conversations
- Including strengths based biopsychosocial assessment Shared decision making and involvement in planning Signposting/ onward referral to outcomes focused interventions
- Sharing of information (in ways that people understand and can act on)
- Enhancing self-efficacy (through building knowledge, skills and confidence)
- support for self-management
- opportunity for behaviour change to support achieved outcomes

In addition, the multidisciplinary team:

- have a single line management
- are locality based, treat people in their own homes and/or within environments meaningful to the person
- meet regularly either virtually or in-person
- have shared resources and processes

Community rehabilitation services may span a wide range of services, delivered by the wider workforce across sectors including voluntary and leisure and focus on specific conditions or issues as well as more generic as shown in Figure 1.

Definition of Community Rehabilitation (continued)

Figure 1. To demonstrate the range of community rehabilitation services

Key Recommendations for Systems

To enable the delivery of high-quality community rehabilitation services, it is recommended that Health Boards and Integrated Joint Boards

1. Appoint a rehabilitation lead accountable at executive level
2. Establish a local provider rehabilitation network to include primary, secondary, tertiary health care, mental health, social care, independent and third sector providers
3. Local systems have a mechanism for engaging with people as part of health system redesign
4. Review existing rehabilitation services to remove silos of care and duplication of services
5. Publish an annual report on rehabilitation

November 2023

Community Rehabilitation Recommendations – Summary Standards

1 **Referral processes are explicit, easy, efficient and equitable**

2 **Rehabilitation interventions should be:**

a. timely

b. co-ordinated both within and between services

c. prevent avoidable impairment

3 **Rehabilitation interventions should:**

a. meet a person's needs and orientate toward outcomes that matter to the person

b. be delivered in the format that is most effective for that person

c. take into consideration any barriers or circumstances that might prevent a person from accessing the service

4 **Rehabilitation pathways should:**

a. address physical, cognitive communication and psychological needs

b. be targeted to those most in need and at risk of inequality

c. be delivered locally where possible

d. allow access to specialist services

5 **The rehabilitation programme should:**

a. be adequate to allow optimisation of function (physical and psychosocial)

b. incorporate facilitating skills acquisition that allow improvement /maintenance/ minimise deterioration of function through self-management

c. include regular review to support ongoing progress toward outcomes / early identification of setbacks/ exacerbations and/or deterioration

6 **The rehabilitation service should be:**

a. well led

b. adequately staffed in terms of range of disciplines, skill mix and expertise

c. supported by a rehabilitation network

7 **The rehabilitation service should:**

a. recognise the role of families and other support networks

b. actively involve families (if the person wants this and the family agree)

c. support families to work with the person receiving community rehabilitation

Community Rehabilitation Standards — Full version

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

Key themes: (a) Self-referral (b) Single point of access (c) Population identification and segmentation (d) Minimising health inequalities.

The patient	The clinician	The service/rehabilitation lead
When I need rehabilitation I am actively made aware of contribution rehab could make to my health and wellbeing, in a way which is right for me. — My GP can refer me. — I can refer myself by contacting the service directly. I know how to do this because — There is a service directory which tells me who and how to contact the service I know when to do this because — My health care practitioner has explained this to me.	I actively promote the contribution of rehab services to people I provide care to. There is a rehabilitation directory which contains the information I need to refer a person to the services they need. If I am co-ordinating the rehabilitation, I can provide the means for the person to contact me directly At discharge, I provide the person with a written rehabilitation plan which includes — Self-management advice — How to maintain or progress function — Contact details for any next steps in the rehabilitation journey — Triggers for review — Routes to review	I provide a directory of rehabilitation services. I ensure that information that specifies the self-referral pathway is easily available, accessible and acceptable. I ensure rapid and skilled triage of patients at the point of entry. The clinicians I manage set their appointment times so that they can support people to self-manage, including learning how and when to self-refer. I work within the rehabilitation network to ensure that the written and online material meets the needs of the local community. I work with the rehabilitation network and social care providers to ensure that when a patient who is receiving social care is referred for community rehabilitation the social care provider is informed. I ensure equity of access and provision. I monitor referrals to ensure that underserved populations are not neglected.

Community Rehabilitation Standards — Full version (continued)

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

Key themes: (a) Self-referral (b) Single point of access (c) Population identification and segmentation (d) Minimising health inequalities.

The network	The planner	The Social Care Provider
The rehabilitation network works with people, carers and local communities as partners to determine how referral pathways can be disseminated effectively to those that may need to access rehabilitation services. The rehabilitation network establishes systems that ensure that when a patient who is receiving social care is referred for community rehabilitation the social care provider is informed.	I have completed a joint strategic needs assessment for rehabilitation services identifying current inequalities in access (and outcomes and future potential demand). I ensure the service planning process includes monitoring of underserved populations. I work with the network and local health care organisations to ensure that inequalities of access are progressively minimised. I use population health management information to understand the needs of the local population and therefore ensure resources are appropriately focus	I know how and when to make a referral to the community rehabilitation service. I am aware of the range of services available to people I care for through reference to the rehabilitation directory. I am informed when a community rehabilitation referral has been made. I know how and when to contact the rehabilitation service for a person I care for. I support people I care for to navigate the community rehabilitation pathway.

Community Rehabilitation Standards — Full version (continued)

Recommendation 2

Rehabilitation interventions are timely, co-ordinated and prevent avoidable ill health

Key themes: (a) early, comprehensive, holistic, biopsychosocial assessment (b)co-ordination of care including (c) information sharing resulting in (c)a clear person-centred journey.

The patient	The clinician	The service/rehabilitation lead
When I am seen — It is by the right person. — It is at the right time. — Everyone I see has all the information from other services that they need — What matters to me and my whole needs are taken into account I know who is responsible for co-ordinating my rehabilitation and how to contact them.	I can undertake a needs led/ outcomes focused, strengths based biopsychosocial assessment. I can work with other disciplines when this would benefit the person I can share information, including up-to-date investigation, medication and test results across the network easily. I am aware of local resources which may facilitate social prescribing and ongoing activity. I know who is responsible for each aspect in the rehabilitation prescription.	I recognise the importance and complexity of the care co-ordination role by allowing enough time to be allocated to this in peoples job plans. I deliver and monitor mandatory training in needs led/ outcomes focused assessment and the biopsychosocial model. I work to ensure that paperwork and IT systems support interdisciplinary and needs led/ outcomes focused approaches including with social care. I ensure that information can be shared between systems easily and effectively. I facilitate case management discussion. I ensure that all team members have a shared understanding of admission and discharge procedures. I recognise the critical contribution social services and care services make — to improving rehabilitation outcomes — to care co-ordination

Community Rehabilitation Standards — Full version (continued)

Recommendation 2

Rehabilitation interventions are timely, co-ordinated and prevent avoidable ill health

Key themes: (a) early, comprehensive, holistic, biopsychosocial assessment (b)co-ordination of care including (c) information sharing resulting in (c)a clear person-centred journey.

The network	The planner	The social care provider
The network involves multiple providers, including primary, secondary and tertiary care, physical and mental health, and social care providers working together to ensure patients are seen in a timely, and coordinated way. The networks engage with providers to ensure information sharing with appropriate governance. The network develops systems that ensure referrals and transfers of care are streamlined throughout the network. The network supports collaborative working practices. The network shares training opportunities and resources. The network is supported by both local social care leaders and providers and the local authority, as well as the rehabilitation lead and planner.	I have walked the 'rehabilitation pathway' with all members of the rehabilitation network including people, carers and local communities as partners to be sure it is timely, efficient and effective for different patient groups.	I am confident that the people I support receive the right service at the right time. Information is shared with me about the person I support; including up-to-date investigation, medication and test results. I feel confident sharing information about the person I support. I have the information I need to provide collaborative care. I know who is responsible for co-ordinating my client's care, and how to contact them directly.

Community Rehabilitation Standards — Full version (continued)

Recommendation 3

Rehabilitation interventions meet a person's circumstances and needs and are delivered in an appropriate format.

Key themes: (a) person centred rehabilitation (b) information provision (c) patient activation (d) shared decision making (e) goal oriented programmes (f) rehabilitation prescription plan

The person	The clinician	The service/rehabilitation lead
I know I have the best rehabilitation for me because — I am given information about different rehabilitation options. — The options are framed in terms of what matters to me. — The information and communciation takes into account my communciation preferences — I can discuss these options with the healthcare professional. — I have time to consider the options. — I can choose the best option for me. — My choice of treatment is written down for me in a 'rehabilitation/ self management plan ' — I can choose different rehabilitation when needed.	I am trained in — Collaborative, outcomes focused and strengths-based approaches — Enhancing self efficacy — person centredness — inclusive communciation — shared decision making — simple behaviour change techniques I deliver evidence-based care. I have the time and skills needed to support necessary change to help people meet their goals. I co-produce rehabilitation/ self management plan with people I share the rehabilitation prescription with relevant providers across the network. I can offer patients a menu of different options for their treatment	I deliver and monitor mandatory face to face training in — Good Conversations — patient activation (self-efficacy theory) — shared decision making — brief consultation skills which support self management and behaviour change — simple behaviour change techniques I work with planners, local clinicians and the rehabilitation network to map current pathways, identify service duplications and service gaps. I work with local clinicians and the rehabilitation network to develop clear pathways for patients with different needs, including those with multimorbidity, and with options for patients with different levels of activation. I work with local clinicians and the rehabilitation network to define and describe those pathways so that clinicians and patients can chose the best pathway for each individual. I ensure staff have time to provide information, undertake patient activation, and shared decision making, recognising that 'front-ending' clinical consultations will save time in the long term.

Community Rehabilitation Standards — Full version (continued)

Recommendation 3

Rehabilitation interventions meet a person's circumstances and needs and are delivered in an appropriate format.

Key themes: (a) person centred rehabilitation (b) information provision (c) patient activation (d) shared decision making (e) goal oriented programmes (f) rehabilitation prescription plan

The network	The planner	The social care provider
The network shares training resources in patient activation. The network shares training resources in shared decision making. The network supports the service to implement best practice recommendations and deliver evidence based rehabilitation. The network supports the integration of research into practice.	I work with the Rehabilitation Lead, local clinicians and the rehabilitation network to map current pathways, identify service duplications and service gaps. I have considered levels of patient activation when analysing local population needs and designing community rehabilitation. I have considered levels of patient activation as part of outcomes-based service planning.	I have the information I need to understand the different rehabilitation options that are available to the person I support. I operate within a Multi-Disciplinary Team and understand the roles of the other team members. I can support people in their decision making around the rehabilitation that best meets their need. I have a copy of the rehabilitation prescription for the person I support and am confident to support its delivery. I have the time and skills to support people to engage in their rehabilitation.

Community Rehabilitation Standards — Full version (continued)

Recommendation 4

Rehabilitation pathways should meet needs, actively target inequalities, and be delivered locally with access to specialist services.

Key themes: (a) needs led rehabilitation (b)integrated services (10, 20, 30 health and social care, physical and mental health) (c)locality-based care (d) access to equipment (e)access to specialists and specialist services.

The person	The clinician	The service/rehabilitation lead
I have co-ordinated support for both my physical and mental health needs. I am seen locally, where possible. When the service I need is not available locally, I am referred onto a specialist service. I am able to access the equipment I need and I am taught how to use and maintain it. I feel confident to progress my rehabilitation treatment programme as needed. I am connected to community based self-management and wellbeing supports in my locality	I know when and how to refer on, and can manage transitions between services effectively. I can work with other local services and with mental health teams in a timely and integrated way to ensure the best outcomes for people . I can access advice from specialist services easily. I am able to refer on to specialist services when indicated. I am aware of and can provide advice about local authority, third sector and other services as well as specialist health services. I feel confident to progress/adapt the person's rehabilitation treatment programme as needed. I have access to the resources to support people to progress their rehabilitation treatment programmes.	I ensure information can be shared, with appropriate governance, between different services and care providers. I provide multidisciplinary input to care homes. I provide the resources which allow patients to progress their rehabilitation including minor pieces of equipment, short telephone contacts, emails, texts, online support.

Community Rehabilitation Standards — Full version (continued)

Recommendation 4

Rehabilitation pathways should meet needs, actively target inequalities, and be delivered locally with access to specialist services.

Key themes: (a) needs led rehabilitation (b)integrated services (10, 20, 30 health and social care, physical and mental health) (c)locality-based care (d) access to equipment (e)access to specialists and specialist services.

The network	The planner	The social care provider
Within the rehabilitation network, specialist services work with place-based services to ensure comprehensive care packages are joined up across the disease trajectory. Within the rehabilitation network, planners and providers work together to ensure integrated systems. Through the network, providers work collaboratively to manage patient needs.	I ensure that patients can have their needs met, by planning local services. I recognise that patients may benefit from working with two services over the same period to optimise outcomes. I ensure services including health care for the elderly and rehabilitation medicine services are delivered in care homes. Where local services cannot meet specialist needs I support 'provider collaboratives and plan 'out of area' services. Where an individual has highly specialist needs I ensure that the pathways for planning these are clear.	I support people to attend appointments. When equipment is needed I can — Obtain and arrange maintenance of equipment. — I am trained appropriately to support people to use the equipment.

Community Rehabilitation Standards — Full version (continued)

Recommendation 5

Rehabilitation Programmes should enable optimisation, self-management and review

Key themes: (a) optimisation of function (b) supported self-management (c) regular review (d) long term conditions registers

The person	The clinician	The service/rehabilitation lead
I am helped to do things that are important to me. The support I receive seems useful to me. I have been told about other services that may be useful. I have been given the information I need. I know what I have to do to look after my condition. I know when to ask for help. If I need to be seen again, I know when this will be. I have the equipment I need and I know how to use it. I know how and when to ask for a review. I am confident I will be reviewed when I need it.	I have an appropriate case load, (that allows time to assess patient activation, undertake shared decision making, and goal setting with the patient, and support self-management). I have the autonomy to decide the most effective dose of rehabilitation. I am aware of diverse social and cultural needs, and am confident in providing effective support. I support patients to maintain their independence, and social roles, including work. I have the time to work with a patient to support their self-management. I am able to work with patients to agree a review date, or when they should self-refer.	I have the budget to ensure adequate staff numbers, and expertise to deliver timely and effective treatment. I deliver and monitor mandatory face to face training in supported self-management. The service I manage provides generic and condition specific structured education courses, both digital and face and face-including accessible psychological support (within the context of condition adjustment and condition management). I ensure the long term conditions register is maintained and patients are offered an annual review. I provide practice placements to support the ongoing workforce supply for effective rehabilitation programmes.

Community Rehabilitation Standards — Full version (continued)

Recommendation 5

Rehabilitation Programmes should enable optimisation, self-management and review

Key themes: (a) optimisation of function (b) supported self-management (c) regular review (d) long term conditions registers

The network	The planner	The social care provider
The rehabilitation network works co-operatively, including people with lived experience, to develop supported self-management approaches including health coaching, self-management education and peer support. The network shares training resources in supporting self-management. The network provides appropriate psychological support within a rehabilitation context and facilitate mental health care where needed (by onward referral) under a matched care and collaborative care approach. The network shares/provides training in best practice for the rehabilitation pathways and programmes provided in the system.	I plan needs led, integrated community rehabilitation services particularly focussing on — Integrated physical and mental health services — Integrated health and social care I plan specialist services with clear access pathways. I commission flexible pathways based on patient need, and outcomes focussed not level of intervention. I plan vocational rehabilitation services. I plan services that support self-management including health coaching, self-management education and peer support. I plan a long-term conditions register which allows regular review of patients with complex disability.	I support people who draw from services to do the activities that are important to them. I support people who draw from care to receive support that is appropriate for their social and cultural needs. I support people who draw from care to feel confident in requesting longer access to rehab if they need it. I know how and when to ask for a review for the person I support.

Community Rehabilitation Standards — Full version (continued)

Recommendation 6

Rehabilitation services are well led, adequately resourced and networked to other services

Key themes: (a) audit, service evaluation and research (b) defining core data, (c) linking data collection to service development.

The person	The clinician	The service/rehabilitation lead
I have been asked to complete questionnaires that record my rehabilitation progress and goals I have opportunities to discuss my progress towards my rehabilitation goals. Providing feedback is easy. I know how my feedback is used. I can see how feedback is used in 'you said, we did' communications.	I have regular clinical supervision, to support my role delivery. I collect data as part of my job plan, including PROMS, PREMS, patient goals and service activity. I am aware of audits and service evaluations running in my department. I am expected to contribute to audits, service evaluations and quality improvement initiatives. I understand where the data I collect is sent. I understand how the data I collect gets used because there is regular feedback. There is a blame free culture which allows me to acknowledge and learn from errors	I ensure the appropriate governance of the community rehabilitation service. I conduct audits and benchmark my services against similar services elsewhere. I identify service priorities and link, collate and review data to these. I ensure staff are aware of the data analysis and how this feeds into service design. I ensure that the information system is appropriate and sufficient to gather and review information on rehabilitation services in order to monitor quality and outcomes. I support a learning culture around compliments, complaints, adverse and serious incidents.

Community Rehabilitation Standards — Full version (continued)

Recommendation 6

Rehabilitation services are well led, adequately resourced and networked to other services

Key themes: (a) audit, service evaluation and research (b) defining core data, (c) linking data collection to service development.

The network	The planner	The social care provider
The rehabilitation network works with patients, carers and local communities as partners to help design services that address unmet need. The network links with the AHSN and other networks to support with service development and design. The rehabilitation network provides mechanisms for sharing good practice and audit findings across the network.	I define the core data set and determinants of success on which to evaluate the service provision. I benchmark the rehabilitation services and plan for progressive improvement in patient access, experience and outcomes. I plan the development of data collection processes for underserved populations. I support services to apply for innovation funding. I support the development of data sets for rehabilitation that offer live feedback and comparisons with national systems.	I can support people drawing from services to access opportunities to discuss their progress towards their rehabilitation goals. I can support people who use services to feedback at appropriate points during their rehabilitation services. I am aware of different ways to feedback (verbally, in writing, online, through questionnaires).

Community Rehabilitation Standards — Full version (continued)

Recommendation 7

Rehabilitation Services involve Families

The friends and family	The clinician	The Service/ Rehab Lead	The network	The planner	The Social Care Provider
What my family experience I am made welcome at my family members appointments. I have the opportunity to ask questions. I am involved in the development of the rehabilitation plan. I can choose how much I am involved in the care and treatment of my family member. I am trained in the use of equipment that is provided. I know where to go for support, (practical, emotional, financial, condition specific), either through the voluntary sector or statutory services. I have the opportunity to feed back about my experience with the service.	I am able to identify which patients rely on carers. I encourage families to attend appointments. I encourage families to ask questions. I am able to include education and training of carers/family in interventions, that optimise generalisation of skills for the patient in their usual environment. I involve families in the development of the rehabilitation plan. I enable the families to have shared knowledge and expectations of rehabilitation. I am confident in engaging carers in the rehabilitation treatment plan to enable its successful implementation. I make sure families are familiar with and confident in the use of any equipment that has been provided. I can recognise when families need support and refer to specialist services when needed.	I have developed pathways to support families. I monitor the experience of families by obtaining feedback.	The rehabilitation network works with patients, carers and local communities as partners to help design services that meet the needs of families, friends and carers.	I plan services that support families of people with disabling conditions.	I keep families informed about changes in function.

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This work was funded by The Chartered Society of Physiotherapy (CSP) Charitable Trust.

Find out more by visiting **www.csp.org.uk/publications/community-rehabilitation-standards**
or scan the QR code

Appendix

Appendix 1 — Expert Reference Group

An external reference group (ERG) for this work was appointed in 2021. Its members were identified by inviting the following organisations to nominate individuals with relevant expertise: British Heart Foundation, British Geriatrics Society, Royal College of Occupational Therapists, Asthma + Lung UK, The Chartered Society of Physiotherapy, National Care Forum, British Society of Rehabilitation Medicine, Royal College of Speech and Language Therapists, British Psychological Society, The Arthritis and Musculoskeletal Alliance, Neurological Alliance

This ensured representation from a broad range of disciplines, working in a variety of settings, academic expertise and wide user representation, through the patient charities.

Its role included:

- Ensuring patient and public involvement (PPI) throughout the development, dissemination and implementation of the guidance
- Deciding the scope and search mechanisms
- Defining a system for the evaluation and presentation of evidence to underpin the guideline recommendations, and
- Deciding the framework for analysing and presenting the guideline
- Overseeing the assembly and evaluation of evidence in accordance with that system
- Agreeing the final production of guidance tools

The ERG met on four occasions:

- To agree the scope of the work, identify key themes, and agree the methodological approach
- To review evidence, agree major content and identify further work
- To review evidence, agree major content and identify further work
- To finalise recommendations and agree dissemination strategies

Patient and public involvement was ensured through firstly involvement of service user organisations from the outset, who helped shape the guidance by:

- Agreeing the search strategy
- Creating the analytic framework
- Interpreting the data
- Developing recommendations

Secondly, by consulting with a wider group of service users through an agency independent of the ERG with expertise in identifying and gathering patient insight, so the voice of the patient is a strong feature of these recommendations.

Appendix 2 — Methodology

A systematic review of the literature was undertaken, including the 'grey literature'. Five key pieces of guidance were agreed as 'core' by the ERG.

These five below were examined and an analysis framework and preliminary codes identified.

British Society of Rehabilitation Medicine Guidance on Specialist Community Rehabilitation

World Health Organisation Community Rehabilitation Guidance

NHS RightCare Community Rehabilitation Toolkit

The National Service Framework for Long-Term Conditions

NHS Rehabilitation Commissioning Guidance for England

This created a framework for further analysis. A further 48 guidance publications were coded using the framework which was modified as the need arose. This followed a comprehensive database search using PubMed, EMBASE, Cochrane Library, PEDro and Psychlit to search clinical practice guidelines (CPG) that reported on community rehabilitation. To search grey literature and CPGs repositories we used the OpenGrey, National Guideline Clearinghouse of the Agency for Healthcare Research and Quality, Guidelines International Network (G-I-N). The reference lists of most relevant CPGs and review articles was scanned for additional CPGs. The database search strategy combined the following search terms: "home based rehabilitation" OR "post ward rehabilitation" OR transitional rehabilitation OR community rehabilitation AND Model* OR Guideline* OR recommendation OR guidance OR "best practice.

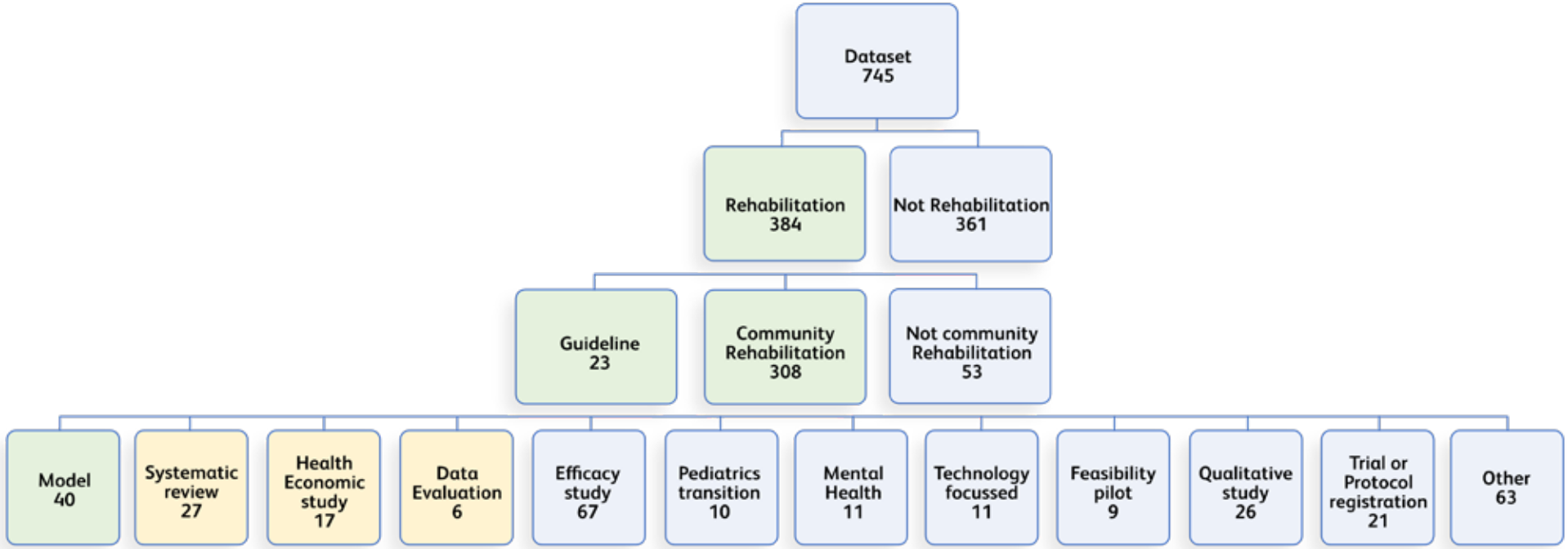
All members ERG were contacted via email to seek any further potentially eligible CPGs. A hand search the major UK health care think-tanks, The Health Foundation, The Nuffield Trust and The King's Fund, was also undertaken.

All records were exported to EndNote X7 (Thomson and Reuters) and duplicates were removed using the software command 'find duplicates' and by manual checking. All non-duplicated titles were screened, abstracts for relevant articles were reviewed and the full text of potentially relevant guidance was retrieved for further analysis. The full texts were examined according to the following inclusion criteria: (1) Relevant to community rehabilitation (2) Provided recommendations or principle.

The documents that have been evaluated include the five key pieces of guidance listed above, and those listed within the recommendations section – appendix 3. (all of which contain hyperlinks to the source).

Appendix 2 — Methodology (continued)

Figure 4.2 PRISMA diagram of Discovery Search



Themes were identified from these codes, from which rehabilitation principles were derived. These principles were then mapped to different components of a comprehensive rehabilitation pathway. The recommendations were informed by the coding, overarching themes and principles. The process was informed by iterative discussions with the ERG. The recommendations were sent out to a professional bodies and national charities for consultation and then modified following feedback.

Audit tools a were developed from the recommendations and standards. A logic model based on the findings, was also developed, as a visual way to illustrate the resources or inputs required to implement standards and recommendations. Both are in the appendices

Appendix 3 — Evidence Review for Recommendations

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

	A Minimise health inequalities	B Population identification & segmentation	C Self referral	D Single point of access
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf	✓	✓	✓	
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf				✓
WHO Rehabilitation 2030: A call for action 2017 www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action	✓			
NICE Cerebral Palsy in Adults [NG119] 2019 www.nice.org.uk/guidance/ng119			✓	✓
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf		✓		✓
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188				✓
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf			✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

	A Minimise health inequalities	B Population identification & segmentation	C Self referral	D Single point of access
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97				✓
NICE Intermediate care including reablement [NG74] www.nice.org.uk/guidance/ng74			✓	✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93		✓		✓
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓		✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services	✓			
NICE Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186				✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

	A Minimise health inequalities	B Population identification & segmentation	C Self referral	D Single point of access
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206				✓
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓			✓
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf	✓	✓		
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng222] 2013 htt	✓			
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138	✓			
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211				✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

	A Minimise health inequalities	B Population identification & segmentation	C Self referral	D Single point of access
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓	✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf		✓		✓
NICE Shared decision making [NG197] 2021 www.nice.org.uk/guidance/ng197	✓			
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf		✓	✓	✓
Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162			✓	
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] www.nice.org.uk/guidance/ng27				✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

ERG commentary

- Referral experience varies; clear for some disease specific conditions, variable for complex multi-morbid conditions
- Increasing capacity and grouping by need rather than diagnosis is required
- Doctors need increased awareness of the importance of early access to rehabilitation
- Referral routes should be inclusive of all clinicians
- Direct access is challenging for some patents but is appropriate, it may mask unmet needs, it is safe, effective and cost-effective
- Terminology around language to describe access and services is variable in the literature
- A single point of access is important to ensure integrated care
- Services need to target those with LTCs, poor health literacy and those in underserved populations to address health inequalities.

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓		✓		
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf		✓	✓		
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	✓
NICE Acute Coronary Syndromes [NG185] www.nice.org.uk/guidance/ng185			✓		
Canadian Stroke Best Practice Guidance 2020	✓	✓	✓		
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf	✓	✓			✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
BSRM Rehabilitation in the wake of Covid-19 – A phoenix from the ashes 2020 www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf			✓		
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188	✓	✓			
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓				✓
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97		✓			
Fusco D, Ferrini A, Pasqualetti G, et al. Oncogeriatrics Group of the Italian Society of Gerontology, Geriatrics. Comprehensive geriatric assessment in older adults with cancer: Recommendations by the Italian Society of Geriatrics and Gerontology (SIGG). Eur J Clin Invest. 2021 Jan;51(1):e13347.	✓				
Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93		✓			
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓		✓	
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services			✓		
NICE Multimorbidity: clinical assessment and management [NG56] www.nice.org.uk/guidance/ng56		✓			
NICE Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186		✓			
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206	✓	✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓	✓	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf					
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22	✓	✓	✓	✓	✓
NICE Osteoarthritis: care and management [CG177] 2020 www.nice.org.uk/guidance/cg177	✓				
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138	✓	✓			
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86		✓			
NICE Rehabilitation after critical illness in adults [CG83] 2009 *www.nice.org.uk/guidance/cg83*	✓	✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211	✓	✓			
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓		✓	✓	✓
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8			✓		
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf			✓		
NICE Shared decision making [NG197] 2021 www.nice.org.uk/guidance/ng197					✓
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf			✓		
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162		✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 2

Rehabilitation interventions are timely, are co-ordinated both within and between services & prevent avoidable disability

	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
NICE Supporting adult carers [NG150] 2020 www.nice.org.uk/guidance/ng150			✓		
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] www.nice.org.uk/guidance/ng27			✓		
WHO Rehabilitation in health systems I Guideline 2017 www.who.int/publications/i/item/9789241549974			✓		

ERG Commentary

- Holistic Multidisciplinary Team (MDT) assessment is required from the first patient presentation
- A biopsychosocial model of care is the preferred mode
- Locality teams are most effective meeting in person or virtually depending on the needs of the team and/or service
- Information sharing is critical which must both adhere to data protection obligations and be enabled by integrated information systems across organisational boundaries
- Care co-ordination between a variety of stakeholders is required to deliver optimal rehabilitation. This role should be recognised and reflected in job plans.
- There needs to be a clear boundary of where care-coordination ends and peer support and/or social prescribing begins to monitor ongoing health behaviours.

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓	✓		✓	✓	✓
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf		✓		✓		
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	✓	✓
NICE Acute Coronary Syndromes [NG185] www.nice.org.uk/guidance/ng185		✓				
RACP Standards for the provision of rehabilitation medicine standards 2014 www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf		✓			✓	✓
Canadian Stroke Best Practice Guidance 2020 www.strokebestpractices.ca/	✓	✓	✓	✓	✓	✓
NICE Cerebral Palsy in Adults [NG119] 2019 www.nice.org.uk/guidance/ng119	✓	✓				

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
NICE Chronic heart failure in adults: diagnosis and management [NG106] www.nice.org.uk/guidance/ng106		✓			✓	
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf			✓			
BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf					✓	
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188		✓		✓	✓	✓
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf		✓				
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97		✓		✓		✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓		✓		
NICE Intermediate care including reablement {ng74] 2017 www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓		✓		✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93		✓		✓	✓	
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf				✓		✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services				✓		
NICE Multimorbidity: clinical assessment and management [NG56] www.nice.org.uk/guidance/ng56	✓			✓	✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
NICE Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186	✓	✓			✓	
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206		✓		✓	✓	
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓		✓	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf						
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22		✓		✓		
NICE Osteoarthritis: care and management [CG177] 2020 www.nice.org.uk/guidance/cg177		✓			✓	
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138		✓	✓	✓		✓

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
The King's Fund: patients as partners 2016 www.kingsfund.org.uk/publications/patients-partners						
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86		✓		✓		✓
NICE Rehabilitation after critical illness in adults [CG83] 2009 www.nice.org.uk/guidance/cg83	✓					
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211	✓	✓		✓	✓	✓
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓		✓		
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8				✓		

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders 2014 www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf				✓		✓
NICE Shared decision making [NG197] 2021 www.nice.org.uk/guidance/ng197			✓			✓
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf				✓		✓
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162	✓	✓				
NICE Supporting adult carers [NG150] 2020 www.nice.org.uk/guidance/ng150		✓				
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] www.nice.org.uk/guidance/ng27		✓		✓		

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in the format that is most effective for that patient

ERG Commentary

- Patient activation is clearly described in the literature. Different levels of patient activation affect delivery of rehabilitation
- Clinical autonomy and a range of rehabilitation options are required to gain optimal results for an individual patient
- Shared decision making is well-evidenced. It is appropriate in non-life-threatening situations and requires partnership between the clinician and patient, information provision and training including co-production
- Rehabilitation prescriptions ought to be embedded in community rehabilitation services.

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf				✓	✓	✓	✓
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓			✓	✓
NICE Acute Coronary Syndromes [NG185] www.nice.org.uk/guidance/ng185						✓	
Australian and New Zealand Pulmonary Rehabilitation Guidelines 2017 https://pubmed.ncbi.nlm.nih.gov/28339144/						✓	
RACP Standards for the Provision of Rehabilitation Medicine Services in the Ambulatory Setting 2017 www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf		✓					
WHO Rehabilitation 2030: A call for action 2017 www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action			✓	✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Canadian Stroke Best Practice Guidance 2020 www.strokebestpractices.ca/		✓				✓	
NICE Cerebral Palsy in Adults [NG119] 2019 www.nice.org.uk/guidance/ng119	✓	✓	✓		✓	✓	
NICE Chronic Heart Failure in Adults: diagnosis and management [NG106] 2018 www.nice.org.uk/guidance/ng106						✓	
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf			✓	✓		✓	
BSRM Rehabilitation in the wake of Covid-19 2020 www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf		✓	✓	✓			✓
NICE Covid-19 rapid guideline:managing the long-term effects of Covid-19 [NG188] 2021 www.nice.org.uk/guidance/ng188	✓			✓	✓		
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf				✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877					✓	✓	✓
Intermediate care including reablement [NG74] www.nice.org.uk/guidance/ng74	✓		✓	✓	✓	✓	
Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93	✓		✓				✓
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf			✓	✓		✓	✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services				✓			
Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186		✓	✓				

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206	✓	✓	✓			✓	
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓		✓	✓	✓	✓	✓
Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22				✓			✓
Osteoarthritis: care and management [CG177] 2020 www.nice.org.uk/guidance/cg177		✓					
Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138	✓			✓	✓		✓
People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86		✓	✓				

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211	✓	✓					
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf			✓	✓	✓	✓	✓
RACP Rehabilitation Medicine physicians delivering integrated care in the community 2018 www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8						✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway 2014 www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓	✓		✓			✓
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf	✓		✓				
Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162		✓	✓				

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 4

Rehabilitation pathways address both physical and mental health, are delivered locally where possible allow access to specialist services

	Access to specialist services	Adequate and timely equipment	Integrated services – health and social care	Integrated services – other	Integrated services – physical and mental health	Locate care in familiar real life situations	Needs led
Supporting adult carers [NG150] 2020 www.nice.org.uk/guidance/ng150		✓					
Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] 2015 www.nice.org.uk/guidance/ng27			✓	✓			
WHO Rehabilitation in health systems | Guideline 2017 www.who.int/publications/i/item/9789241549974	✓	✓		✓			✓

ERG Commentary

- Integrated needs-led services are well supported in the literature and can streamline complex and silod care pathways.
- Diagnosis led services are inflexible and do not meet the needs of people with multi-morbid presentations.
- Integration is required across primary, secondary and tertiary services
- Rapid access to specialist services is essential, particularly for locality based services
- Equipment provision must not be ignored and should include training for staff, the patient and the wider family/carers if required

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 5

he rehabilitation programme is adequate to allow optimisation of function, incorporates teaching the skills that allow maintenance of function through self-management, includes regular review for people with complex disability that is likely to deteriorate.

	Optimise function	Regular review	Supported self management
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf		✓	✓
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf			✓
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	
RACP Standards for the provision of rehabilitation medicine standards 2014 www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf		✓	
Canadian Stroke Best Practice Guidance 2020		✓	✓
NICE Cerebral Palsy in Adults [NG119] 2019 www.nice.org.uk/guidance/ng119	✓	✓	
NICE Chronic heart failure in adults: diagnosis and management [NG106] www.nice.org.uk/guidance/ng106		✓	✓
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf			✓
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188		✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 5

he rehabilitation programme is adequate to allow optimisation of function, incorporates teaching the skills that allow maintenance of function through self-management, includes regular review for people with complex disability that is likely to deteriorate.

	Optimise function	Regular review	Supported self management
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf			✓
NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓	
NICE Intermediate care including reablement {ng74] 2017 www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓		
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93		✓	
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓	✓
NICE Multimorbidity: clinical assessment and management [NG56] www.nice.org.uk/guidance/ng56		✓	
NICE Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186	✓	✓	
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206	✓	✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 5

he rehabilitation programme is adequate to allow optimisation of function, incorporates teaching the skills that allow maintenance of function through self-management, includes regular review for people with complex disability that is likely to deteriorate.

	Optimise function	Regular review	Supported self management
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf	✓		
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22	✓	✓	✓
NICE Osteoarthritis: care and management [CG177] 2020 www.nice.org.uk/guidance/cg177	✓	✓	✓
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138	✓		✓
The King's Fund: patients as partners 2016 www.kingsfund.org.uk/publications/patients-partners	✓		
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86	✓		
NICE Rehabilitation after critical illness in adults [CG83] 2009 www.nice.org.uk/guidance/cg83		✓	
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211		✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 5

he rehabilitation programme is adequate to allow optimisation of function, incorporates teaching the skills that allow maintenance of function through self-management, includes regular review for people with complex disability that is likely to deteriorate.

	Optimise function	Regular review	Supported self management
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf		✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders 2014 www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf			✓
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf			✓
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162		✓	
WHO Rehabilitation in health systems I Guideline 2017 www.who.int/publications/i/item/9789241549974	✓		✓

ERG Commentary

- Optimisation of function is the core element of a rehabilitation intervention
- Regular review is supported in the literature and enables rehabilitation to change as the patient's need's change
- Self-management is supported in the literature and has the key elements of Information provision, Patient activation through health coaching, patient education and Peer support, for example through

social prescribing

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation ?
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓		✓	✓	✓	
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf	✓		✓	✓	✓	
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf						
RACP Standards for the provision of rehabilitation medicine standards 2014 www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf			✓	✓	✓	
WHO Rehabilitation 2030: A call for action 2017 www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action	✓		✓	✓	✓	
Canadian Stroke Best Practice Guidance 2020			✓		✓	

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation ?
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf			✓	✓	✓	
BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf						
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188			✓		✓	
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97			✓		✓	
Health Foundation Social care briefing www.health.org.uk/topics/social-care			✓		✓	
NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877			✓		✓	

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation ?
NICE Intermediate care including reablement {ng74] 2017 www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓					
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93	✓	✓		✓		
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓			✓		
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf				✓		
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf						
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22						

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation ?
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86						✓
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211			✓		✓	
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓		✓	✓	✓	✓
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8		✓		✓		
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓					
Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders, 2014. www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓					

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation ?
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162			✓		✓	
WHO Rehabilitation in health systems I Guideline 2017 www.who.int/publications/i/item/9789241549974	✓					

Table 2 – Workforce	Interdisciplinary and multi agency	Education	Leadership	Skill mix and expertise	Team culture
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓			✓	✓
Transforming Community Neurology 2016 www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf	✓			✓	
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	
RACP Standards for the provison of rehabilitation medicine standards 2014 www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf	✓	✓			

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 2 – Workforce	Interdisciplinary and multi agency	Education	Leadership	Skill mix and expertise	Team culture
Canadian Stroke Best Practice Guidance 2020	✓	✓		✓	
BSRM Rehabilitation in the wake of Covid-19 – A phoenix from the ashes 2020 www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf	✓				
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188	✓	✓			
King's Fund: Delivering better services for people with long term conditions 2013 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓	✓	✓		
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97				✓	
NICE Intermediate care including reablement {ng74] 2017 www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓	✓	✓	✓
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf		✓		✓	

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 2 – Workforce	Interdisciplinary and multi agency	Education	Leadership	Skill mix and expertise	Team culture
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf		✓		✓	
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf		✓		✓	
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22		✓		✓	
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138				✓	
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86		✓		✓	
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211				✓	
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓	✓	✓	

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

Table 2 – Workforce	Interdisciplinary and multi agency	Education	Leadership	Skill mix and expertise	Team culture
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8	✓				
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓		✓	✓	
NICE Shared decision making [NG197] 2021 www.nice.org.uk/guidance/ng197		✓	✓	✓	✓
Nuffield Shifting the balance of care [2017] www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf	✓		✓	✓	
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162				✓	
NICE Supporting adult carers [NG150] 2020 www.nice.org.uk/guidance/ng150	✓				
WHO Rehabilitation in health systems I Guideline 2017 www.who.int/publications/i/item/9789241549974	✓	✓	✓	✓	

Appendix 3 — Evidence Review for Recommendations (continued)

Recommendation 6

The rehabilitation service is well led, adequately staffed in terms of range of disciplines, skill mix and expertise, supported by a rehabilitation network

ERG Commentary

- Benchmarking in community rehabilitation services is challenging
- Uniformity of data sets and data collection is essential
- An interdisciplinary, multiagency workforce with strong leadership is critical to the delivery of successful community rehabilitation
- Workforce shortages across a number of healthcare groups is apparent, meaning career pathways are critical
- Leadership needs to extend all the way through the organisation to a Rehabilitation Lead role that is held by a rehabilitation experienced health care professional

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 7

The rehabilitation service recognises the role of families, actively involves families (provided this is what the patient and the family want), supports families to work with patients

	Carer support	Involve families where appropriate
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓	✓
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓
NICE Acute Coronary Syndromes [NG185] www.nice.org.uk/guidance/ng185		✓
Canadian Stroke Best Practice Guidance 2020	✓	✓
NICE Cerebral Palsy in Adults [NG119] 2019 www.nice.org.uk/guidance/ng119		✓
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 www.nice.org.uk/guidance/ng188		✓
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 www.nice.org.uk/guidance/ng97	✓	
NICE Intermediate care including reablement {ng74] 2017 www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 www.nice.org.uk/guidance/ng93	✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 7

The rehabilitation service recognises the role of families, actively involves families (provided this is what the patient and the family want), supports families to work with patients

	Carer support	Involve families where appropriate
King's Fund Making our health and care systems fit for an ageing population 2014 www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓
NICE Multimorbidity: clinical assessment and management [NG56] www.nice.org.uk/guidance/ng56		✓
NICE Multiple sclerosis in adults: management [CG186] 2019 www.nice.org.uk/guidance/cg186	✓	
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 www.nice.org.uk/guidance/ng206	✓	✓
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf		
NICE Older people with social care needs and multiple long-term conditions [NG22] www.nice.org.uk/guidance/ng22	✓	✓
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 www.nice.org.uk/guidance/cg138		✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 7

The rehabilitation service recognises the role of families, actively involves families (provided this is what the patient and the family want), supports families to work with patients

	Carer support	Involve families where appropriate
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 www.nice.org.uk/guidance/ng86		✓
NICE Rehabilitation after traumatic injury [NG211] 2022 www.nice.org.uk/guidance/ng211	✓	✓
Commissioning Guidance for Rehabilitation 2017 www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf		✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders 2014 www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓	✓
NICE Shared decision making [NG197] 2021 www.nice.org.uk/guidance/ng197		✓
NICE Stroke rehabilitation in adults [CG162] 2013 www.nice.org.uk/guidance/cg162	✓	✓
NICE Supporting adult carers [NG150] 2020 www.nice.org.uk/guidance/ng150	✓	✓
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] www.nice.org.uk/guidance/ng27	✓	✓

Appendix 3 — Evidence Review for Recommendations (continued)

Principle 7

The rehabilitation service recognises the role of families, actively involves families (provided this is what the patient and the family want), supports families to work with patients

ERG Commentary

- The role of both formal and informal carers is important and must be recognised
- The tension between engaging families and expecting families to support rehabilitation is recognised

Appendix 4 — Audit Tools

Audit tools for patients

Audit statement	Likert scale	Evidence for Director's report
How I get seen		The self audit questionnaire for patients and family's should be collected and collated routinely/regularly. This should be presented in the Rehabilitation Lead's report with an analysis of compliments and complaints. Further evidence of engagement with patients, family, friends and carers to develop, and improve services should be presented based on work within the network, c.f., recommendations 1. The rehabilitation network works with patients, carers and local communities as partners to determine how referral pathways can be disseminated effectively to those that may need to access rehabilitation services. 2. The rehabilitation network works with patients, carers and local communities as partners to help design services that address unmet need. 3. 'The rehabilitation network works with patients, carers and local communities as partners to help design services that meet the needs of families, friends and carers'
My GP can refer me when I need rehabilitation		
I know how to refer myself for rehabilitation	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
There is a service directory which tells me about different rehabilitation services in my area	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
I know when I should be seen again in the rehabilitation service	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
Who does what?		
My health care professional knows how to treat me	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
I am seen at the right time for my condition	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
My health care professional has all the information s/he needs from other people involved in my care	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	
I know who is responsible for co-ordinating my care and how to contact them	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree	

Appendix 4 — Audit Tools (continued)

Making sure the treatment meets my needs	
I am given information about different treatment options	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I can discuss these options with my health care professional	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I have time to consider the options	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I can choose the best option for me	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
My choice of treatment is written down for me in a 'rehabilitation prescription'	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I can choose a different treatment if I need to	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
Making sure I can access specialist services	
I have co-ordinated support for both my physical & mental health needs	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I am seen locally, where possible	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
When the service I need is not available locally, I am referred onto a specialist service	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree
I am able to access the equipment I need and I am taught how to use and maintain it	○ Agree ○ Mostly Agree ○ Mostly Disagree ○ Disagree

Appendix 4 — Audit Tools (continued)

How I know my rehabilitation is effective	
I have been helped to do things that are important to me	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
The support I received seems helpful to me	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I have been told about other services that may be useful	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I have been given the information I need	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I know what I have to do to look after my condition	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I know when to ask for help	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
If I need to be seen again, I know when this will be	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I have the equipment I need and I know how to use it	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I know how and when to ask for a review	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I am confident I will be reviewed when I need it	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
Obtaining and providing feedback	
I have been asked to complete questionnaires that record my rehabilitation progress and goals	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree

Appendix 4 — Audit Tools (continued)

I have opportunities to discuss my progress towards my rehabilitation goals	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
Providing feedback is easy	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I know how my feedback is used	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I can see how feedback is used in 'you said, we did' communications	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
What my family, friends and carers can expect – FFC to complete	
I am made welcome	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I can ask questions	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I am involved in the development of the rehabilitation plan	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I can choose how much I am involved	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I am trained in the use of equipment	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I know where to go for support	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
I can feedback about my experience with the service	◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree

Appendix 4 — Audit Tools (continued)

Audit tools for clinicians

Recommendation	Self Audit Statement with Likert scale ◯ Agree ◯ Mostly Agree ◯ Mostly Disagree ◯ Disagree
Referral process	
I am able to work with patients to identify the triggers that mean they should be reviewed	When I discharge patients, I provide them with written specific, and measurable triggers for review
As part of any discharge conversation, I am able provide written materials (a rehabilitation plan) that identifies the triggers that mean a patient should be reviewed	When I discharge patients, I provide a written rehabilitation plan The rehabilitation plan contains triggers for review
As part of any discharge conversation, I am able provide written materials (a rehabilitation plan that explain the referral process, including self-referral through the single point of access	My rehabilitation plans explain how the patient can be reviewed
If I am the patients keyworker, I can provide the means for the patient to contact me directly	If I am the patients keyworker, I can provide the means for the patient to contact me directly
I am aware of the range of services available to patients, and can identify appropriate services and their referral routes through reference to the directory	There is a rehabilitation directory which contains the information I need to refer a patient to the services they need
Efficient and co-ordinated care	
I can undertake a needs led, biopsychosocial assessment	I can undertake a needs led, biopsychosocial assessment
I am able to access and work with a multidisciplinary team with relevant skills to treat each patient	I can work with other disciplines when this would benefit the patient

Appendix 4 — Audit Tools (continued)

I can share information, including up-to-date investigation, medication and test results across the network easily	See above There is a rehabilitation directory which contains the information I need to refer a patient to the services they need.
I am aware of local resources which may facilitate social prescribing and ongoing activity	
Accurate targeting of treatment	
I am trained in patient activation	I am trained in patient activation.
I am trained in shared decision making	I am trained in shared decision making
I am trained in simple behaviour change techniques	I am trained in simple behaviour change techniques
I have the time and skills needed to support necessary change to help patients meet their goals	I have the time and skills needed to support necessary change to help patients meet their goals.
I can contribute to a co-produced detailed rehabilitation prescription/ plan which I share with the patient and relevant providers across the network	I co-produce a rehabilitation prescription/plan with my patients I share the rehabilitation plan with relevant providers across the network
I deliver rehabilitation based on the best available evidence	I am confident that my treatment is based on up to date evidence.
I can offer patients a menu of different options (depending on their preference and level of activation) including ‘do nothing’, supported self-management, individual, group, F2F, blended and telehealth options	I can offer patients a menu of different options for their treatment
Access to core and specialist services	
I know when and how to refer on, and can manage transitions between services effectively	I know when and how to refer on to other rehabilitation services. I am confident my referrals to other rehabilitation services are seen in a timely way.

Appendix 4 — Audit Tools (continued)

I can work with other local services and with mental health teams in a timely and integrated way to ensure the best outcomes for patients	There are clear pathways that allow me to refer patients to mental health services. I am confident my referrals to mental health services are seen in a timely way.
I can access advice from specialist services easily	I can access advice from specialist services easily
I am able to refer on to specialist services when indicated	I am able to refer on to specialist services when indicated
I am aware of and can provide advice about local authority, third sector and other services as well as specialist health services	See above There is a rehabilitation directory which contains the information I need to refer a patient to the services they need.
I feel confident to progress/adapt the person's rehabilitation treatment programme as needed	I can progress or change the patient's rehabilitation as indicated
I have access to the resources to support people to progress their rehabilitation treatment programmes	I know when and how to refer on to third sector services I am confident my referrals to third sector services are seen in a timely way.
Adequate treatment programme	
I have an appropriate case load, that allows time to assess patient activation, undertake shared decision making, and goal setting with the patient, and support self-management.	I have an appropriate case load that allows time to assess patient activation, undertake shared decision making, and goal setting with the patient, and support self-management.
I have the autonomy to decide appropriate course of treatment, based on patient need, goals and outcomes	I have the autonomy to decide appropriate course of treatment, based on patient need, goals and outcomes.
I am aware of diverse social and cultural needs, and am confident in providing support that is equitable	I have attended ED&I training
I support patients to maintain their independence, and social roles, including work	I support patients to maintain their independence, and social roles, including work.
I have the time to work with a patient to support their self-management	I have the time to work with a patient to support their self-management,

Appendix 4 — Audit Tools (continued)

I can signpost appropriately and effectively to information and support, including to social prescribing link workers	
Monitoring service provision	
I collect data as part of my job plan, including PROMS, PREMS, patient goals and service activity	I collect PROMS and PREMs and report these to my department.
I am aware of audits and service evaluations running in my department	I attend regular departmental audit meetings
I am expected to contribute to audits, service evaluations and quality improvement initiatives	Quality improvement initiatives and service evaluations in my department lead to improvements in care
I understand where the data I collect is sent	
I understand how the data I collect gets used because there is regular feedback	My department analyses the data I collect. The results of the data analysis are provided to me regularly.
I work within a culture that celebrates excellence and which allows me to acknowledge and learn from errors	I work within a culture that celebrates excellence and which allows me to acknowledge and learn from errors
Family, friends and carers	
I identify which patients rely on carers	I identify which patients rely on carers.
I encourage families to attend appointments	I encourage families to attend appointments.
I encourage families to ask questions	I encourage families to ask questions.

Appendix 4 — Audit Tools (continued)

I involve families in the development of the rehabilitation plan and aim to develop a shared expectations of rehabilitation	I involve families in the development of the rehabilitation plan and aim to develop a shared expectations of rehabilitation
I am confident in engaging carers in the rehabilitation treatment plan to enable its implementation'	I am confident in engaging carers in the rehabilitation treatment plan to help its implementation'.
I make sure families are familiar with and confident in the use of any equipment that has been provided	I make sure families are familiar with and confident in the use of any equipment that has been provided.
I can recognise when families need support and refer to specialist services when needed	I can recognise when families need support and refer to specialist services when needed.

Appendix 4 — Audit Tools (continued)

Audit tool for Directors

Referral process	Rehabilitation Lead's report
I ensure that that information that specifies the direct access pathways is easily available in a variety of formats	Summary table, of information available, formats and languages. For those disseminated through web based and digital technologies, to include appropriate metrics such as number of visits to site, number of downloads.
I ensure rapid and skilled triage of patients through the access point	Time between first contact and treatment implementation
The clinicians I manage have the autonomy to set their appointment times so that patients are supported to self-manage, including learning how and when to self-refer	
I work within the rehabilitation network to ensure that the written and online material meets the needs of the local community	Minutes of meetings at which this is discussed,
I monitor referrals to ensure that underserved populations are not neglected	Referral data analysed by age, gender, disability and race
I ensure reasonable adjustments are made to ensure equity of access and provision	Referral data analysed by age, gender, disability and race
I provide a directory of rehabilitation services and a map which demonstrates potential flow of patients through the system	Include map, and link to directory
I ensure the map and directory is updated as required, no less frequently than annually	Date of latest update
Who does what	
I recognise the importance and complexity of the care co-ordination role by allowing enough time to be allocated to this in peoples job plans	

Appendix 4 — Audit Tools (continued)

I deliver and monitor mandatory training in needs led assessment and the biopsychosocial model	Mandatory training data
I work to ensure that paperwork and IT systems support interdisciplinary and needs led approaches	A gap analysis has identified inefficiencies in the systems from a clinical perspective and the requirements for good clinical care identified. There is a strategic plan to address this.
I ensure that information can be shared between systems easily and effectively	
I facilitate case management discussion	
I ensure that all team members have a shared understanding of admission and discharge procedures	In house training
Accurate targeting	
I deliver and monitor mandatory face to face training in patient activation	Mandatory training data
I deliver and monitor mandatory face to face training in shared decision making	Mandatory training data
I deliver and monitor mandatory face to face training in simple behaviour change techniques	Mandatory training data
I work with planners, local clinicians and the rehabilitation network to map current pathways, identify service duplications and service gaps	Key findings of map and gap with link to report.
I work with local clinicians and the rehabilitation network to develop clear pathways for patients with different needs, including those with multimorbidity, and with options for patients with different levels of activation.	Service specifications and descriptors
I work with local clinicians and the rehabilitation network to define and describe those pathways so that clinicians and patients can chose the best pathway for each individual	Service specifications and descriptors
I ensure staff have time to provide information, undertake patient activation, and shared decision making , recognising that ‘front-ending’ clinical consultations will save time in the long term	Staff numbers, disciplines and grades

Appendix 4 — Audit Tools (continued)

Core and Specialist services	
I ensure information can be shared, with appropriate governance, between different services and care providers	Evidence of how information is shared and governance maintained.
I provide multidisciplinary input to care homes	Numbers of local care homes, residents in those homes and how rehabilitation is provided.
I provide the resources to support behaviour change and which allow patients to progress their rehabilitation including minor pieces of equipment, short telephone contacts, emails, texts, online support	
Adequate Treatment Programme	
Adequate Treatment Programme	Staff numbers, disciplines and grades
I have the budget to ensure adequate staff numbers, and expertise to deliver timely and effective treatment	Budget, and proportion spent on staffing
I deliver and monitor mandatory face to face training in supported self-management	Mandatory training data
The service I manage provides generic and condition specific structured education courses, both digital and face and face.	Education courses offered and number of attendees
I ensure the long term conditions register is maintained and patients are offered annual review	Report on long term conditions register, numbers on register, primary and secondary diagnoses, numbers reviewed
I provide practice placements to support the ongoing workforce supply for effective rehab programmes'	Relationships with training organisations and number of placements offered each year. Feedback on placement experience.
Monitoring provision	
I conduct audits and benchmark my services against similar services elsewhere	Summary audit reports

Appendix 4 — Audit Tools (continued)

I identify service priorities and link, collate and review data to these	
I ensure staff are aware of the data analysis and how this feeds into service design	
I ensure that the information system is appropriate and sufficient to gather and review information on rehabilitation services to monitor quality and outcomes	PROMS, PREMS, patient goals and service activity
I support a learning culture around compliments, complaints, adverse incidents and SUIs	Staff survey
Family, Friends and Carers	
I have developed pathways to support families.	Annual report
I monitor the experience of families by obtaining feedback	Family surveys.

Appendix 5 — Directors Annual Report

The Directors Annual report should include:

1. Description of population served by the Health Board/Integrated Joint Board
2. Description of service planning, service budget, organisation, services including access routes, mapping and gaps
3. Description of number of therapists and other staff, banding, discipline, including vacant posts, staff turnover, and long term sick, and training placements offered
4. Description of approaches taken to ensure
   - a. Patients are aware of access routes
   - b. direct access by patients
   - c. integrated health and social care,
   - d. integrated physical and mental health,
   - e. vocational rehabilitation services
   - f. relationships with independent providers and the third sector, including provision of services to care homes
   - g. appropriate and easy information sharing consistent with information governance
   - h. identification and co-ordination of care of patients with complex needs, including long term conditions registers
   - i. access to provider collaboratives
   - j. access to 'out of area' services
5. Approaches to and results of feedback from family, friends and carers
6. Compliments, complaints and SUIs
7. Audits, service evaluations, quality improvement initiatives

The patients and their family, friends and carers

1. Process measures – access routes used, numbers of patients seen, diagnostic categories, ED&I data, wait times, number of times patients seen, Routine PREMS and PROMS and feedback from families

The clinicians

1. Mandatory training record with description of type and delivery of training
   - a. Patient activation
   - b. Shared decision making
   - c. Behaviour change
   - d. ED&I
   - e. Account of in-service training
   - f. Study leave taken and funds provided

The network

1. Account of network structure and work streams