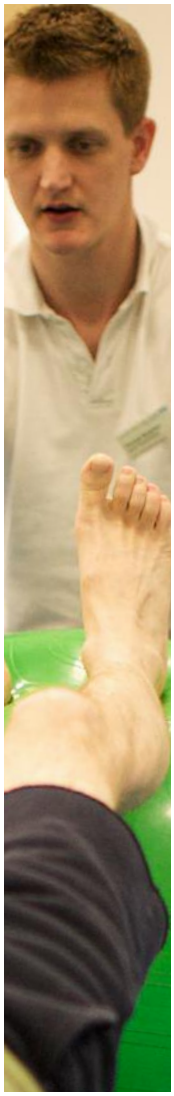
NHS
Improving Quality

IMPROVING ADULT REHABILITATION SERVICES IN ENGLAND

Sharing best practice in acute and community care



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INTRODUCTION

This report is designed to provide examples of good practice in rehabilitation services and to highlight the common elements that have contributed to improved patient outcomes. It supports NHS England's understanding of the role rehabilitation has within local and national priorities (see Appendix B), which will strengthen the alignment and positioning of rehabilitation within the whole system of transformational improvement work.

Case studies on a wide range of services were identified via the Improving Adult Rehabilitation Services Community of Practice NHS Networks website[1] on which providers and commissioners are able to post and share examples of where they have developed and redesigned rehabilitation services, as well as through referrals from stakeholders to NHS Improving Quality. However, due to the sheer breadth of services known to be available they are by no means exhaustive. It is recognised that there are many different rehabilitation teams and models in operation within the NHS employing innovative practices not featured in this paper, and it is hoped that the examples will act as a starting point from which to further develop the evidence base.

The following rehabilitation services were defined as in 'scope'[2] for inclusion as a case study:

- Adult rehabilitation services (including physical and mental rehabilitation)
- Transition from specialised rehabilitation services to adult rehabilitation services
- Transition from children's and young people's rehabilitation services to adult rehabilitation services.

This work was commissioned on behalf of NHS England, the National Clinical Director for Rehabilitation and the Chief Allied Health Professions Officer. It was authored by NHS Improving Quality.

[1] www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services
[2] See Appendix A for further definition of scope and categories of need used in rehabilitation

BACKGROUND

There are many definitions of rehabilitation and reablement. For the purposes of this document the working definition adopted by NHS England and developed in partnership with a range of clinical experts will be used, with rehabilitation defined as, 'the restoration, to the maximum degree possible, of an individual's function and/or role, both mentally and physically, within their family and social networks and within the workplace where appropriate.' However, it is recognised that there are many other definitions of rehabilitation.

Current services cover an enormous spectrum in the patient pathway, from support to re-learn basic cognitive skills, right through to exercise classes to improve physical fitness. Referral to rehabilitation can be triggered by acute or chronic mental and/or physical illness. Treatment can be provided in an acute setting (during an inpatient episode or as an outpatient referral), and/or in the community on discharge from an acute Trust, or via primary care (with a small number of community providers accepting self-referral). In addition to NHS provision, patients may choose to self-refer and pay for private providers.

Services in England incorporate a wide range of health and social care professionals such as doctors, nurses, physiotherapists, podiatrists, social workers, occupational therapists, and counsellors, working directly for/ in rehabilitation or as part of a wider multi-disciplinary team.

They are predominantly commissioned by Clinical Commissioning Groups but can be directly commissioned by NHS England (see above section in Introduction on scope and Appendix A).

In relation to clinical governance, professional guidelines and quality standards relating to rehabilitation in specific conditions or illnesses are often produced by specialist professional bodies, for example, the Association of Physiotherapists in Cardiac Rehabilitation.[3] In addition, there are national organisations such as the National Institute for Health and Care Excellence (NICE)[4] and the Scottish Intercollegiate Guidelines Network[5] (SIGN) who produce information on clinical guidelines, as well as guidance in relation to healthcare models and commissioning.

[3]Association of Chartered Physiotherapists in Cardiac Rehabilitation http://acpicr.com/publications
[4]NICE www.nice.org.uk
[5]SIGN www.sign.ac.uk

COMMON ELEMENTS AND TOP TIPS

A number of common rehabilitation-specific elements were identified in the case studies reviewed, which may provide wider learning.

1. Integrated service models with health and social care

A significant level of change is likely to occur (for staff and patients alike) by altering commissioning arrangements, from speciality based approaches (as 'add ons' to other specifications) to an integrated or pooled model between numerous health and social care providers, with an outcomes- based approach.

This is often instigated through multi-agency boards or commissioning networks and arises as a result of reviewing existing rehabilitation services. This does not mean that specialists are not brought in to the patient pathway, or that certain rehabilitation services are not separately commissioned, but it does mean that specialists are more likely to operate within the same service or locality as part of the same team - which may reduce silos of interventions for the patient. There are a number of different examples of 'integrated' care within the case studies as follows:

Formally integrated health and social care – where multi-disciplinary teams have been newly created and commissioned to provide rehabilitation services (see the **Greenwich** and **Cheshire** case studies) or where previously specialist teams have come together to work within one overarching rehabilitation structure, which streamlines the referral process and reduces the number of providers a patient has contact with. See the **Sandwell and Birmingham** case study.

Informal integrated working across health care settings – where teams work collaboratively (but separately funded) across different healthcare settings to provide a more unified pathway and transition for patients. See the **South East London** example.

a. Commissioning support for an integrated model

There are many sources of support available for local areas who want to take this approach forward. National commissioning guidance[6] and how to use pooled budgets[7] with the local authority can be helpful but, as shown in the **South of Tyne and Wear** and **Bristol**, **North Somerset** and **South Gloucestershire** examples, the Commissioning Support Unit could be the best place to facilitate initial discussion between Clinical Commissioning Groups and providers. There is also a Community of Practice network established by the Chief Allied Health Professions Officer[8] which can provide further examples of integrated services.

Within the case studies a number of services began their improvement programmes by reviewing current services against population need. Patient pathways were redesigned to reflect the potential 'future state' and commissioners and providers worked together to look at the varying financial options available.

[6] Kings Fund www.kingsfund.org.uk/sites/files/kf/Integrated-care-summary-Sep11.pdf
[7] Commissioning Support www.commissioningsupport.org.uk/pdf/20_Partnership_and_pooled_budgets.pdf
[8] Improving Adult Rehabilitation Services
www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/#COP

There are different ways of commissioning similar end facing services for the patient. Two examples of this are **Bristol, North Somerset and South Gloucestershire** and **South of Tyne and Wear**.

b. Integrated IT systems

One of the biggest barriers cited to improving communication between services and ultimately integration (especially in relation to health and social care) is the lack of cohesion between IT systems, which primarily creates the problems of duplicate records and lack of care history amongst professionals working with the same individual. This is because IT systems are normally created on a service need basis, and so the content and purpose of each system can vary dramatically. They can be bought from and housed by different organisations or companies (public and private), with different software protocols and procedures for confidential information access and sharing.

There are two main approaches services have taken to mitigate these problems; either one IT system for all, or find a way to get all the different systems to interface. One example of the latter option in practice is **Bristol, North Somerset and South Gloucestershire** 'Connecting Care' IT procurement programme, which will overarch existing IT systems between health and social care.

2. Single point of assessment or referral

Many care referrers can be unaware of the rehabilitation services available within their locality - or unsure of the referral criteria for these services. This creates a barrier for patients who may be at differing stages in their rehabilitation pathway, require multiple referrals to several different services, or want a staged approached to their care.

In addition (or as an alternative) to producing a local collective 'directory of services' one solution is to introduce a single point of contact - also known as single point of referral (SPR)/access (SPA) – for rehabilitation referrals within the community. This can vary by referrer and is dependent on services available/ commissioned locally. Examples of differing models of this include **Sandwell and Birmingham** who have introduced a SPR for everyone, **South of Tyne and Wear** who have introduced a SPR for primary care, and **Greenwich** which offer a SPA for GPs, A&E and paramedics.

Many of the single point of access models work extended hours and are available across a seven day period, for example **Greenwich**. This is invaluable for referrers with 'emergency' patients who need access to services throughout the weekend, and without which they would become a hospital admission. Many providers of the SPA/ SPR also have community teams with extended hours who will respond immediately. Examples include the **Greenwich** Joint Emergency Team (JETS) and **Sandwell and Birmingham** community team who have a 'red' referral response time of three hours.

3. Early intervention

Early intervention with rehabilitation gives the patient significantly improved outcomes and faster recovery time.[9] Examples which support this statement in different ways include:

Following trauma - **South East London** amputee service demonstrated that early access to prosthesis (at a rehabilitation centre that operated seven days a week), reduced the time for lower limb amputees to become independent with a fitted prosthesis from three months to seven weeks.

Pre-habilitation – the pulmonary rehabilitation support for elective lung surgery model at **Heart of England** introduced early intervention as part of an enhanced recovery pathway.[10] The pilot has introduced elements of exercise, education and lifestyle modification and has seen a reduction in the number of patients experiencing post-operative complications following lung cancer surgery, compared with those on the traditional pathway.

Urgent response/admission avoidance – **Sandwell and Birmingham** community team feature a seven day a week single point of access (8am to 8pm) where referrals are triaged into red, yellow and green. A red referral is seen within three hours and as a result of this rapid response they are currently achieving a 93% admission avoidance rate amongst patients referred.

4. Self-management

- Involves an individual learning more about their condition and making supported decisions based on this
- Aims to enable people to make daily decisions that will maintain or improve their health
- Assumes a person's own priorities/aims/goals are what are most likely to motivate them to change their behaviour
- Is an essential part of any health service

South West London and St George's Mental Health NHS Trust

Self-management is often advocated as part of the holistic management plan to reduce recovery time and improve long-term outcomes (including admissions avoidance) in a number of patient groups, for example for those with long-term conditions.

[9] www.evidence.nhs.uk/fragility+fractures
[10] Enhanced Recovery www.nhs.uk/conditions/enhanced-recovery/Pages/Introduction.aspx

However, access to appropriate and adequate resources and support are required to enable patients and their family/carers to self-manage effectively. Rehabilitation services can now access a wide range of evidence-based literature, support materials and interactive services (such as free phone helplines from public and voluntary sector organisations) to aid care planning. One good example of this is the breadth of material available for COPD.[11]

Alternatively services may use their own materials, such the **South of Tyne and Wear** Wellbeing Star programme. This is an adaptation of the 'Outcomes Star' - a self-management model[12] which moves the patient from the medical to the social model of recovery. It was originally created for the homeless but has now been used within mental health and learning disabilities and was chosen by **South of Tyne and Wear** as a validated tool which met the requirements for their patients. It is highly person-centred and designed to put the patient in control of their recovery through a structured journey of change.

5. Self-referral

In addition to self-management, self-referral is another aspect of a model which helps to empower the patient, give them confidence with the service and put them at the centre of their care.[13]

Self-referral can operate either through initial first contact or through re-referral back in to a service, often after receiving prior treatment or support. The benefits of offering this can include:

- Choice (to have the capacity and power to act alone and decide when)
- Direct access (no need for intermediary intervention such as GP)
- An immediate response (awareness of what will happen next).

Examples of self-referral in practice can be found within the **South East London**, **Adult Ability** and **Sandwell and Birmingham** case studies. The **Sandwell and Birmingham** model accepts any self-referral and is able to signpost patients on to different providers if they are not the most appropriate service for the need.

[11]See British Lung Foundation materials www.blf.org.uk
[12]Triangle Consultancy www.outcomesstar.org.uk
[13]Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_116358.pdf

6. Flexibility of workforce

The most flexible rehabilitation service models often contain a workforce with a broad range of professionals and a wide skill mix. Lack of integration (silo working) is inefficient. Multi-disciplinary teams enable planners to think differently about the type of service and the response they can offer to optimise resources. For example, **Sandwell and Birmingham** and **Trafford** have generalist teams but contain specialists who are able to take individual patient referrals where a specific need arises.

Rehabilitation needs can be incredibly diverse but patients need early access to the right professionals in order to aid recovery and positive experience. Many of the case studies report additions to the normal staffing expectations (nurses and physiotherapists), working across care setting and boundaries, as they continue to understand where the patient need lies.

Examples of this are:

- **Cheshire's** transitional intermediate model which includes a social worker within the bed management team
- **South East London** regional amputee service, where lower limb amputees following the recovery pathway are referred on to a rehabilitation centre which operates through a multi-disciplinary team which includes podiatrists and orthotists
- **South of Tyne and Wear**, who have increased their workforce skills mix and capacity by looking beyond the traditional view of a rehabilitation 'therapies' workforce utilising third sector providers.

TOP TIPS

The following top tips were taken from the best practice shared in the case studies.

1. **Local data is crucial and gives the evidence base to support and make the change**
2. **Clinical champions who can promote and support service improvement are vital**
3. **Service open days can raise awareness and help with stakeholder engagement**
4. **Patient feedback is powerful in understanding problems and driving change**
5. **Identify or create incentives within rehabilitation for outcomes-based commissioning**
6. **Current service review should be undertaken as a starting point for any potential changes**
7. **Professional guidelines/evidence-based care is available - but not always followed**

CASE STUDY 1

North of England Commissioning Support Unit

Developing a rehabilitation strategy for South of Tyne and Wear to drive improvement

Context

Sunderland, Gateshead and South Tyneside (a population of approximately 620,000 people) were lacking a cohesive approach to the commissioning of rehabilitation services in the area. Rehabilitation rarely featured as a separate entity in contracts and was generally included in secondary or tertiary block contracts included in NHS tariffs.

Action

In 2008, an overarching strategy for the region was developed, based on four key principles:

1. Person centred services and outcomes
2. Accessibility
3. Equity and partnership working
4. Effective evidence-based practice

Key objectives of the strategy are to:

- Establish a single point of registration for rehabilitation services, preferably electronically linked to primary care
- Make better use of tele-health in the early stages of COPD, falls and cognitive problems
- Ensure there is early access to rehabilitation for people with long-term conditions
- Pilot a person-centred outcome tool – the 'Recovery/ Wellbeing Star' in cardiac and pulmonary rehabilitation
- Develop a rehabilitation patient self-management manual which will be written into new rehabilitation specifications (to be rolled out from 2014)
- Build capacity by utilising the third sector, health trainers and exercise professionals
- Improve support for patients around vocational and employment opportunities, for example by engaging more with local work programme providers
- Improve psychological support in rehabilitation, particularly for those with mental health long-term conditions

Quality specifications for commissioning have also been developed (from national guidance documents) in cardiovascular disease, chronic obstructive airway diseases, cancers, acquired brain injury, long-term neurological conditions, falls, vocational rehabilitation and stroke (where detailed rehabilitation interventions have been included in the commissioning specification).

Impact

Specific examples of how the strategy has led to practical service developments include:

The rehabilitation/ health club model for COPD, CVD and those at risk of falling

This is a primary care orientated early rehabilitation model including primary care navigation, psychological support and peer support. Potential capacity for rehabilitation was increased through input from NHS health trainers (in public health) and the third sector, and pulmonary rehabilitation places have risen from 120 to 300 without additional funding. Investment from Sunderland CCG will increase this further to 500 in 2014/15. In addition procurement for a new pulmonary rehabilitation service in Gateshead has been completed after approval of a business case by the local CCG.

Refresh rehabilitation

The refresh service is designed to allow access to refresher rehabilitation for people with on-going needs. Patients with long-term needs are discharged with a re-referral option, meaning they can access rehabilitation when they need it.

Sudden onset – multiple trauma, critical illness and acquired brain injury

Patients with mild to moderate and complex brain injury cases will be assisted by a specialist team, as well as peer support, to focus on social and vocational outcomes. The aim is for specialist teams to support intermediate care services/reablement services to enable this to happen more. This is specifically part of the new acquired brain injury service currently under procurement and proposals for neurology outpatient services (Sunderland). The business case for the model has been approved and the procurement tender is underway, plus an additional £800k has been secured to build on the small community assisted brain injury service.

CASE STUDY 1

Challenges

- Changes to the commissioning structure slowed the strategic overview and continuity
- Engagement with services who did not have a clinical champion was more difficult
- Systematic use of an outcome measure was slow
- Development of single point of referral was slow due to organisational change
- Contracting teams can negate intentions in specification
- A specification for rehabilitation has been written and is currently being piloting with local providers

TOP TIPS

- Include/ liaise with contracting team to work on quality/outcome issues not only performance data
- Strategic leadership in commissioning and liaison with clinical networks and tertiary services
- Include a specification for rehabilitation in contracts
- Rapid improvement workshops were valuable in engaging with stakeholders in the pathway
- Identify levers for change with clinical and commissioning champions
- Use epidemiological data effectively to illustrate the scale of the case for local change

Contact

Ailsa Nokes, Head of Customer Programme
Email: ailsa.nokes@nhs.net
Tel: 0191 2172647

CASE STUDY 2

South West Commissioning Support Unit

An integrated rehabilitation strategy for Bristol, North Somerset and South Gloucestershire

Context

In 2012 the Bristol North Somerset and South Gloucestershire Healthy Futures Programme Board[14] (HFPB) commissioned a project to review current services and agree new models of care in order to make more effective use of therapy time and achieve a more 'joined up' approach to services for the local population (960,000 people).

The two major drivers were the need to clarify the availability of rehabilitation facilities after the reduction of rehabilitation hospital beds from 150 to 100 (post the opening of North Bristol Hospital) and to maximise resources to achieve a high quality, financially stable health care system.

Action

The HFPB provided the mandate, governance and helped manage the review across the wider community. It was clinically led and managerially driven by the Clinical Commissioning Groups and the local authorities. Some of the key findings included:

- Recognition that there are many examples of good practice in rehabilitation services but these are often speciality specific
- Acknowledgement of service gaps, particularly in post-acute and community provision, yet there were many opportunities for generic working
- A further review of the section of Bristol Health Services Plan (from 2003) relating to the new hospital in North Bristol - which originally stated that 100 rehabilitation beds would be retained (32 at the new hospital and 68 at a community facility)
- Evaluation of a reablement service pilot project, which has subsequently been rolled out across South Gloucestershire and is still expanding in capacity

Five workstreams were established to lead the improvement work on the services:

1. Demand and capacity – A one month audit (May 2013) to determine appropriate rehabilitation bed usage was undertaken at four acute hospital sites, three community hospitals and a residential reablement centre, using the Rehabilitation Complexity Scale[15] (RCS). An additional section was added to the RCS to allow assessors to record their opinion on an 'appropriate treatment venue' for each patient[16] to determine the potential for community-based rehabilitation. The audit recorded 1658 patients and found that patients needing rehabilitation were spread across a number of wards over four hospital sites, creating inefficient use of therapy time. Furthermore, 38% of patients in an acute bed did not need that level of intervention, they rated below level six.
2. Finance option appraisal – to look at moving resource from the acute hospital to the community.
3. Commissioning end to end – to review how to commission the provision of a full range of rehabilitation services in a joined-up manner.
4. Care co-ordinator role option appraisal – to explore how this role could be established to act as a single point of contact for patients and to take an overview of the patient's care. A 'discharge hub' was set up to identify the level of need on the RCS and undertake daily joint assessments by acute and community staff.
5. Shared paperwork – to determine if a single set of paperwork per patient could be created. This has included developing a 'rehab prescription' for inpatients and plans are underway for a pilot between acute and community teams. To support this 'Connecting Care' (a Bristol North Somerset and South Gloucestershire wide IT procurement programme) will deliver the potential to share individual patient data across health communities (to extend to social care in the future). A 'portal' is being set up to overarch existing IT systems rather than trying to agree a common system with associated costs.

CASE STUDY 2

Impact

- A contract schedule has been created for the new services which specifies that rehabilitation is only paid for patients identified as level five on the RCS whilst on the rehabilitation ward
- Pilot models are currently underway in two of the CCGs to expand rehabilitation services
- Capacity in rehabilitation at home has increased to include 38 additional nursing home beds
- The 'rehab prescription' is now being piloted for all inpatients
- One acute Trust is now using a care co-ordinator and another is using the discharge hub

Challenges

- Initial narrow viewpoints and 'short-term' thinking were mitigated by sign up to a common goal
- Commissioning seamless rehabilitation due to the number of commissioners involved
- Organisational change leads to loss of corporate memory which takes time to rebuild

TOP TIPS

- Beware of different interpretation of terminology around integration and coordinated care
- Invest time in the preparation stages for any audit and to get stakeholder buy in, as this enables robust reliable data to be consistently collected - but pilot it first
- Ensure good buy in up front from all of the key stakeholders, which may take time and need a persuasive case, but time invested here will save much more time later
- Establish a shared purpose to drive process and sustain momentum

Contact

Elizabeth Williams, Project and Service Redesign Manager
Email: elizabeth.williams@swcsu.nhs.uk
Tel: 0117 900 2480

[14]This is a partnership board made up a number of statutory commissioning and provider health organisations, along with local authorities, across the Bristol, North Somerset and South Gloucestershire area. The partnership's aims are to 'achieve a financially sustainable health system which prevents illness, maintains independence and streamlines pathways'.
[15]A scale created by Turner-Stokes, Disler and Williams (2007) to identify patient level of need
[16]6 = acute bed, 5 = non-acute bed with daily medical, nursing and therapy input, 4 = non-acute bed with nursing and therapy input and reactive GP cover, 3 = non-acute bed in residential facility with therapy input and reactive GP cover and 2 = home with personal care and/or therapy input

CASE STUDY 3

Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Community Services

Rapid response service providing rehabilitation to older people

Context

The Joint Strategic Needs Assessment published by the Primary Care Trust (at that time) identified the need to improve the outcomes of vulnerable older people, particularly around long-term conditions, falls and early prevention of vascular dementia, with a focus on reducing admissions to hospital and premature admissions to care homes.

There was also recognition from senior health and social care staff that current services were disjointed and reactive, whilst feedback from the patients and carers suggested that services were not achieving efficiency and quality in outcomes.

Action

In response, Greenwich Community Intermediate Care Services and Royal Borough of Greenwich Adult and Older Peoples Services have worked collaboratively to redesign services for older people. A joint governance board (including commissioners) was established and the current patient pathways were mapped to identify gaps and blockages. The service model, processes and pathway were then redesigned by a multi-professional group of health and social care staff.

Highlights of the model include:

- Single initial point of access incorporating referral pathways
- Local healthcare staff, including community assessment and rehabilitation, joint emergency teams (JETS – see below) and hospital integrated discharge teams, were reconfigured and aligned with social care and care support services in order to provide CCG cluster practice level support
- The goals for the teams, along with community nursing and long-term conditions teams, are:
  1. Support avoidable admission to hospital
  2. Support rehabilitation after discharge from hospital
  3. Help avoid premature admission to care homes
  4. Reduce domiciliary care packages by promoting self-management
- Introduction of JETs comprising of nurses, physiotherapists, occupational therapists and social workers, for GPs, A&E and paramedic referrals (via mobile/pages), operating seven days a week from 7.30am to 8.30pm (apart from social workers), to provide an immediate response to prevent hospital admission
- Weekend input from a social worker has not been needed as the team are able to modify care packages themselves and during busy periods, when there is a surge in demand or winter pressures, it is possible to step the social care support up to seven days a week
- Hospital Integrated Discharge (HID) facilitates speedy discharge to intermediate/ social care
- Community Assessment and Rehabilitation (CARS) provides up to six weeks rehabilitation and ongoing social care linked to and working with a home care reablement service (seven days a week)
- Support for self-management area on the Oxleas website[17]

Plans are now underway for total integration to coordinate patient and service users care with primary and mental health care colleagues and the third sector.

Impact

- JETS team data (collated daily) indicates that since April 2011 a total of 2771 unscheduled admissions have been prevented – allowing patients to remain in their own homes for treatment and care
- As a result of introducing the JETs team, the community COPD service has been able to reduce their hours of work from 7am-7pm to 7am-5pm seven days a week
- Savings of £900k were achieved within the domiciliary care budget during 2011/12 and sustained in 2012/13
- Musculoskeletal service now being adapted using this model
- Pilots for extending diabetes and memory clinics to seven days now in consideration

CASE STUDY 3

Challenges

- Some disconnection from GPs early in the project
- Differing professional cultures and beliefs within health and social care staff and teams
- Early successes created concern that expectations may not be fulfilled and a potentially unrealistic demand would be placed on the service - however this did not materialise

TOP TIPS

- Base the immediate response/admission avoidance team close to A&E and community services for ease of access and to support relationship building
- Allow the change process sufficient time to be completed thoroughly
- Maintain support for the team and recognise pressure can escalate during sickness absence or staff shortage
- Having two named individuals within the paramedic service to work with the virtual admission avoidance project helped considerably
- Engage staff in the redesign process through a collaborative and bottom up approach

Contact

Jane Wells
Email: jane.wells@oxleas.nhs.uk
Tel: 020 8319 7156

Please note: This case study is also featured as an exemplar of wider seven day service provision in the NHS Improving Quality publication NHS Services – open seven days a week: every day counts[18] and is available, along with other case studies on NHS Improving Quality's website.[19]

[17] www.oxleas.nhs.uk/long-term-conditions
[18] NHS Improving Quality (2012) NHS Services – open seven days a week: every day counts available at: www.nhsiq.nhs.uk/8763.aspx
[19] NHS Improving Quality www.nhsiq.nhs.uk/media/2422270/greenwich_cs_final.pdf

CASE STUDY 4

Sandwell and West Birmingham Hospitals NHS Trust

Developing a single integrated community rehabilitation service – the 'ICARES' Service

Context

Previously, three teams offering different rehabilitation services (care management of long-term conditions, admissions avoidance and community rehabilitation) operated within the Sandwell and West Birmingham area. Waiting time from referral to rehabilitation exceeded 40 days. Patients and staff feedback stated that the existing system created silo working.

Commissioners and service users decided that they wanted easier access into the service and less complicated pathways. As a result in October 2012 the Integrated Care Services (ICARES) came into effect – one team for every community referral for the local population (approximately 320,000 people).

Action

ICARES is an amalgamation of three previously separate teams (see above). It started from an idea and an evidence-based framework, which was then discussed with commissioners, local GPs and union representatives. Team engagement began in April 2012 with a 'Listening into Action' event where every staff member could hear about the framework and start to contribute to the operational detail.

Proactive clinical leadership over the next six months enabled all staff to engage in a series of events to continue working up the operational policy, which included staff completing an options appraisal for the structure of the new service. Clinical leaders were readily available with open doors and regular briefings kept staff informed of progress. Formal management of change took place with human resources. Post 'go live' the clinical leadership was (again) heavily proactive to assist with any issues and ensure new processes were embedded.

ICARES was launched in October 2012. It is commissioned by Sandwell and West Birmingham Clinical Commissioning Group and provided by Sandwell and West Birmingham Hospitals NHS Trust.

There are approximately 120 staff in the new service including nurses, physiotherapists, occupational therapists, speech and language therapists and health assistance personnel (who can fit adjustments within the patient's home to increase mobility and independence). The service receives approximately 10,000 referrals per year.

The key elements of the ICARES model include:

- Single point of access for all adult (aged 16+ years) rehabilitation referrals (including self-referral), between 8am and 8pm which are then triaged and streamed into red, orange and green for response
- Red stream referrals are seen within three hours for immediate intervention, orange within 72 hours and green within 15 days
- Response is provided by integrated locality teams with a focus on self-management where possible
- Teams consist of generalists and specialists who can take individual referrals depending on need (e.g. speech and language therapists, neurological physiotherapists, multiple sclerosis specialists etc.)
- Although not integrated with social care the service is co-located and can refer on easily and quickly
- All staff have access to hospital patient records as acute Trust staff but also access to SystmOne – the community based IT system which 80% of GPs in the area use

As well as the above service for referrals, ICARES is also the gateway to intermediate care in the locality. The team oversee discharge from hospital to one of the 150 intermediate beds in the locality and then provide the therapy and care management in the intermediate care bed bases, as well as on discharge into the community.

The new model was provided at no extra commissioner investment, it was entirely service redesign.

CASE STUDY 4

Impact

- 93% admissions avoidance in terms of referrals who would have been taken to hospital
- DNAs and cancelled appointments in the service have reduced from an average of 48 per month to 18 per month (1% of activity)
- 95% of patients rated the service as eight or more (out of 10) in the family and friends test

Challenges

- Six months for the management of change process between decision to integrate and go-live was a challenging deadline
- Embedding new ways of thinking and working so that all staff followed the processes and variation is reduced to a minimum
- Proactive management to ensure all staff felt engaged and could contribute irrespective of their band and profession

TOP TIPS

- Staff know the answers and how to run the service – give them ownership of the redesign project e.g. writing operational policies
- Share metrics with the staff weekly on all aspects of operational performance to provide motivation, encouragement and recognition of achievements
- It is not necessarily about specialism – it is about providing for the patient's clinical need

Contact

Ruth Williams, Integrated Care Service Manager
Email: ruth.williams2@nhs.net
Tel: 0121 507 2664

CASE STUDY 5

The Dudley Group NHS Foundation Trust

Development of an integrated community rehabilitation service

Context

The existing rehabilitation services for the population (approximately 312,000 people) were provided through a number of different teams, such as stroke or speech and language therapy, who were either entirely community or clinic based.

Segregation of specialties meant that pathways for patients were often disconnected (with multiple 'handoffs') and the quality of care provided varied depending on who received the referral. Each team had separate referral criteria and forms, and waiting times for some teams breached the recommended maximum within their service specification.

A scoping exercise on a cohort of patients within the service revealed one individual who had received care from 5 different teams (22 professionals) over the course of their treatment.

Action

In 2011 a 'listening into action' event was held for staff to try and establish current pathways, where there were issues in the existing delivery model and where redesign was necessary. A number of themes were pulled together and subsequently developed into a service improvement project.

A new model for delivery was created around:

- Integrating services and bringing individual teams together (community and acute based staff - as well as local authority staff employed via the hosted brain injury service)
- Setting up a single point of access
- Triage of referral by clinical staff (currently phone or paper with plans for electronic shortly)

Members of existing staff were also asked to look at competencies in the service and determine which commonly performed tasks required generalist knowledge and which needed specialist skill, and to lead improvement work streams to pull together the new model ready for launch.

The new service commenced on 1 July 2013 and operates five days per week, with an aspiration to move to seven days in the near future. It covers 49 GP practices across five townships and receives approximately 45-50 referrals per week, categorised into urgent and seen within two weeks (but normally within days) and routine – up to six week wait. Self-referral is also available.

A new IT system is also being implemented which will allow clinicians access to patient records (through smart phones/ iPads) when out in the community.

The team recognises that there are still gaps in provision around avoiding admissions and delayed discharge. Work continues on the relationship between the service and the acute Trust, such as building rehabilitation staff into the new rapid response nursing service starting in April, and providing an in-reach service for stroke and early supported discharge patients.

No additional monies were received from commissioners for this work – all redesign was completed within existing budgets.

Impact

- Waiting times have significantly reduced for access to some specialists, for example the wait for occupational therapy has decreased from up to ten weeks to a few days, and all referrals are seen within waiting time parameters
- Patient and staff satisfaction surveys are currently underway and the whole service is undergoing a six month inception review

CASE STUDY 5

Challenges

- There are currently only two clinic facilities available within the locality which do not open at the weekend, thus restricting ability to work seven days
- Staff raised concerns over the proposed integration of teams, fearing loss of specialist titles and the perception of the label 'generalist'
- Staff who had previously only worked in the community (and vice versa in clinic) were concerned around changes to the working environment

TOP TIPS

- Engage with all relevant commissioners from the outset and maintain the engagement throughout the service improvement
- Do not assume staff will automatically be able to adapt and transfer skills and abilities to new settings, additional training may be needed
- In hindsight, one large event for staff to consult with over the new model was not enough – further staff engagement and consultation events would have been beneficial before the new service was agreed

Contact

Carrie Spafford, Interim Deputy Director
Email: carrie.spafford@dgc.nhs.uk
Tel: 01384 456111

CASE STUDY 6

South Cheshire Clinical Commissioning Group

Commissioner led redesign of extended rehabilitation service

Context

Commissioners within Cheshire were keen to undertake transformational redesign of a number of services in the locality - including the current pathways for patients with medical and social care needs in hospital awaiting discharge.

This work was instigated due to high demand on A&E at the hospital resulting in breaches of the four hour wait target. In addition, space on wards was in high demand for new admissions yet existing patients were waiting in beds for appropriate discharge venues.

Action

A number of changes were made in A&E at the front end of the hospital pathway but the question still remained around improving flow on exit for certain patients. A gap in provision was identified for patients who no longer needed treatment, long-term care or nursing home placement (medically fit) but could not immediately go home.

The work undertaken for these patients centred on impacting the part of their pathway which would achieve the most benefit for the investment/ effort made.

The redesign team created a 'transitional care concept' by commissioning a new route out of hospital into specialised beds designed with packages of care to meet the above gap in need. A local authority intermediate care facility (a 42 bedded unit) was chosen (which continued to operate for those with respite needs and learning difficulty) and within that facility a number of beds (nine in total) have been commissioned, primarily for social care but with medical support. These beds are for a maximum three week stay and are covered by staff including medical cover via a GP (who offers three programmed activities per week), a social worker and a physiotherapist. The team has sight of the discharge and local practices make summaries available. The patient's medical record is entered as a temporary resident through the practice EMIS system.

The criteria for patients who have been discharged into these beds begin from the assessment within hospital that they are 'medically fit' and able to go home. They no longer need medical care but can have mobility needs particularly if immobilised during the hospital stay. Examples of the type of illness on discharge include urinary tract infections, falls, collapse, post-operative wounds etc. and a high proportion of these patients previously went to residential or nursing care. They now have more time to aid their medical recovery further and establish the best place for them to meet their overall needs. This often requires social support (packages of care or reablement) based on individual circumstances.

The model is now being expanded around the locality including an additional 17 beds in other local rehabilitation venues.

Impact

The impact of the expanded intermediate and transitional social care beds is incredibly hard to quantify because they are inextricably linked with other improvements being made throughout the whole health system within the area.

However, some of the high level improvements that have been seen include:

- Four hour wait target within A&E being met – with the exception of special cause due to seasonal variation
- Lower admission rates to nursing homes from patients in transitional care going through the system within the prescribed timescales
- Cost of new intermediate care model is approximately £250 per week whereas the same patient in a hospital bed would cost £450 per week
- Collaborative approaches to care involving health and social care staff have created new opportunities, for example GPs out of their normal working environment

CASE STUDY 6

- Qualitative interviews have elicited positive feedback from patients who have used the new pathway
- GPs have learned to work in a sessional commitment more like a geriatrician role
- The service was initially only available in one of two CCGs using the hospital. Patients initially declined to go to similar social care beds without medical input but are now happy to do so

Challenges

- Extracting data to show evidence of outcomes for this model has been difficult due to the links with other improvements taking place
- Inadvertent perverse outcomes, for example, managing new demand - commissioners reduce nursing home places and create alternative models to aid this, yet demand for nursing homes increases as elderly patients move to the area for nursing home care as it is perceived as more desirable

TOP TIPS

- The skills and attitudes of the people running the service (function) matter
- Staff on the ground must see the vision being created and own the changes being made
- The creation of a team allows the doctor to support others and get the best from all the skills available
- The service has a high throughput and requires different systems and higher staffing levels to cope with the numbers and help patients to "do it themselves" and regain confidence
- The GPs have assimilated the new skills and used them in their General Practice role

Contact

Dr Andrew Spooner
Email: andrew.spooner@btinternet.com
Tel: 01270 256340

CASE STUDY 7

South East London Regional Amputee Service and Guy's and St Thomas' NHS Foundation Trust

Integrated amputee rehabilitation service

Context

The average length of stay for patients who had undergone lower limb amputation surgery at St Thomas' or King's College Hospital was 40 days. Patients were discharged from the acute care unit either into intermediate care beds or home with local outpatient rehabilitation, which may not have been specialised.

Action

An integrated specialist multi-disciplinary amputee rehabilitation unit (based on the British Association of Chartered Physiotherapists in Amputee Rehabilitation guidelines) was set up in response to evidence showing lower limb amputee recovery and mobility was most improved with early access to intensive rehabilitation by a multi-disciplinary specialist team (MDT), with early prosthesis provision and a drive towards integrated care. The aims of the service were:

- To decrease length of stay in the hospital after surgery
- Improve outcomes through early access to intensive specialist MDT rehabilitation
- Reduce social care burden
- Provide specialist MDT input to those patients who would most benefit, versus those who were predicted to have good outcomes via other pathways.

Post-surgical patients accepted at the 12 bed unit (which opened in Lambeth in June 2013) are now discharged from hospital when medically fit anytime from 10 days post amputation. Early assessment and preparation for the rehabilitation starts with staff in the acute setting, who work closely with the staff at the rehabilitation unit via means of (weekly) joint MDT ward rounds. Members of staff from the prosthetic limb centre also attend the ward round to ensure that patients who will most benefit from the services at the unit are referred.

Pressure on beds often leads to patients who have been given a prosthetic in an acute setting being discharged into a 'micro' environment, with little or no independence and becoming increasingly reliant on wheelchair use. This slower stream outpatient rehabilitation pathway was not intensive enough to reverse reliance on carers and a wheelchair for many lower limb amputees.

The new service at the amputee rehabilitation unit involves a cast being taken in the acute post-operative phase when the patient is clinically prepared. It is built and ready to be fitted within four to five working days, intensive prosthetic rehabilitation then begins immediately. Amputees are reviewed by the physiotherapist and prosthetists at one, three, six and 12 months after receiving their prosthesis using validated outcome measures and progress against patient set goals.

Patients spend an average of seven weeks working towards their rehabilitation goals. On discharge home from the Lambeth unit they are followed up by the specialist outpatient regional prosthetic rehabilitation team at Bowley Close. As well as individual rehabilitation there is access to exercise classes, education and advice sessions, a fully equipped gym and a rehabilitation garden.

Ongoing prosthetic review, repair and provision from Bowley Close continues on a lifelong basis. Self-referral through an emergency open access clinic is available without appointment (Monday to Friday) for new episodes of therapy treatment due to changing health and or physical mobility, or if there is a need for emergency repairs.

Patients outside of the Bowley catchment area are referred to the regional prosthetics centre commissioned by their Clinical Commissioning Group.

CASE STUDY 7

Impact

- Early data suggest that 80% of patients who were admitted are now independently mobile with their prosthesis on discharge from the amputee rehabilitation unit
- Average length of stay on the ward at St Thomas' reduced from 40 to 22 days
- Patient outcomes were measured at the 1 month prosthetic review using the BACPAR recommended validated tools including; the two minute timed walk test, timed up and go (TUAG) and the LCI5 (locomotor capability index five),[20] as follows:

Tool	Baseline score	Previous pathway	Bowley Centre pathway
LC5	5/56	10/56	25/56
Two minute walk test	N/A	32 meters	60 meters
TUAG	N/A	55 seconds	35 seconds

Challenges

- Commissioner engagement
- Staff shift patterns to accommodate seven day working
- Bottle necks in the new pathway
- Impact of rehabilitation centre provision and changing the patient pathway may have an unpredictable effect on other local community rehabilitation and prosthetic services

TOP TIPS

- Clinical champions e.g. specialist therapy leads, a service manager with background in prosthetics and consultant in rehabilitation helped progress the business case
- An open day will help showcase the service on offer – especially to commissioners
- Business cases may need several iterations and attempts to commissioners before approval

Contact

Angela McCrae, Head of Specialist Rehabilitation Services
Email: Angela.McCrae@gstt.nhs.uk
Tel: 020 3049 7700

[20]BACPAR tools include the two minute timed walk (individual walks without assistance for two minutes and the distance is measured), TUAG test (the time that a person takes to rise from a chair, walk three metres, turn around, walk back to the chair, and sit down) and the LC5 (a validated measure of lower-limb amputees' ability to perform activities with prosthesis)

CASE STUDY 8

Heart of England NHS Foundation Trust

Pulmonary rehabilitation support for elective lung surgery

Context

Almost 5000 operations to cure lung cancer take place every year in the UK. Lung complications, readmission to hospital after surgery and breathlessness are common after surgery and have a significant impact on the patient and the NHS, however these can be significantly reduced by getting lung surgery patients fitter in the weeks before and after surgery. Heart of England NHS Foundation Trust (HEFT) recognised this and developed and tested a fitness programme (of pulmonary rehabilitation) that is now standard practice for their lung surgery patients.

Action

In 2010 the thoracic surgery team at the Trust led by Mr Babu Naidu, Associate Professor at the University of Warwick and Consultant Thoracic Surgeon at Heart of England NHS Foundation Trust, ran a feasibility study (funded by the Health Foundation) to compare the model of pre and post-surgical pulmonary rehabilitation with the standard care pathway for the recovery of surgical lung cancer patients.

Diagnostic work was undertaken to determine baseline elements including data on patient demand, the current patient pathway and the availability and capacity of additional services currently operating in the localities. Teams of health professionals such as physiotherapists, dieticians, consultants and smoking cessation advisors at the pilot sites were then brought together to agree the new model and how it would work in practice.

The new pathway introduced four tenets of COPD pulmonary rehabilitation to lung surgery patients:

1. Nutritional assessment to identify nutritionally depleted patients and appropriate interventions for them
2. Pulmonary rehabilitation exercise programme (no additional funding) utilising existing classes primarily attended by COPD patients
3. Smoking cessation advice and support
4. Patient self-management education which covers all aspects of surgery and recovery – including DVD and self-management strategies

Referral in is via the multi-disciplinary team once a surgical intervention has been chosen as the treatment. Before surgery patients are assessed by the lung clinical nurse specialist for smoking status and body mass index, given a date for pulmonary rehabilitation and educational elements. They are referred to a dietician for dietary advice and for smoking cessation support in the community (if needed) and attend pulmonary rehabilitation twice weekly up until surgery. Surgery was never delayed so the time spent on the programme before surgery was variable with patients attending on average four sessions before surgery. At the first pulmonary rehabilitation class they are given an additional one hour for a fitness assessment and education with the physiotherapist. After surgery patients attend pulmonary rehabilitation for another six sessions and are then discharged.

Patient recovery is measured through a number of clinical outcome indicators such as exercise capacity and lung function as well as performance measures including: length of stay, hospital re-admission and complication rate.

Impact

- So far the programme has been evaluated with 58 patients, compared with a non-intervention group of 305 patients over the same period[21]
- Post-operative pulmonary complication rate 16% non-intervention versus 9% intervention
- Readmissions 5% in intervention and 14% in non-intervention
- Total cost of intervention group per patient = £1284 versus non-intervention = £1528 representing a cost saving of £244 per patient

The programme has become standard practice at the Trust and the team is helping to spread the model throughout the country via a manual and DVD which has captured all four elements of the programme.

[21]Eur J Cardiothorac Surg. 2013 Oct: 44(4):e266-71

CASE STUDY 8

Challenges

- The initial diagnostic mapping work to gather all the required data in order to formulate the programme
- Getting clinicians and allied health professionals from different streams to work together e.g. COPD and lung cancer
- Some centres were missing key elements needed for the pathway e.g. an NHS run pulmonary rehabilitation service
- Not all patients were interested in participating in the additional elements e.g. pulmonary rehabilitation

TOP TIPS

- Communication is the key to a successful referral process and programme
- Develop clear and simple pathways and test
- Identify any training and knowledge needs
- Audit outcomes
- Engage and collaborate with different teams of staff when redesigning the pathway

Contact

Amy Kerr, Thoracic Nurse
Email: amy.kerr@heartlands.nhs.uk
Tel: 0121 424 2966

Please note: This models also aligns with the principles of enhanced recovery (see Common elements section, page 7) which are now being spread across acute medicine as part of the national enhanced recovery programme.[22]

[22]Enhanced Recovery - www.nhs.uk/conditions/enhanced-recovery/Pages/Introduction.aspx

CASE STUDY 9

Pennine Care NHS Foundation Trust and Trafford Community Rehabilitation Services

Developing standardised rehabilitation guidelines to reduce local variation

Context

Community rehabilitation in the Trafford area is provided across four separate neighbourhoods within the borough. Previously, the geographically based locality teams predominantly operated separately from one another. This highlighted the potential for patients in different areas to receive variation in clinical care and outcomes.

Action

In 2009 team leader Debra Maloney reviewed several approaches to standardise the clinical options available to patients across the borough. The four locality teams and the out-patient rehabilitation team (approximately 28 staff) came together to map three key areas, which were:

1. All the current conditions for which they offer rehabilitation
2. A list of every assessment for each condition
3. A list of all the evidence-based interventions/ treatment performed for each condition

All this information was collated in a hard copy document and a colour coding system was devised to indicate the level of skill required to undertake all the interventions and treatments currently offered. For example, general tasks which a registered clinician performed were coded red, but a specialised therapy intervention, such as Cognitive Behavioural Therapy, would be green.

Members of the team were encouraged to consider their areas of interest and skills, which were then pooled into an overarching list. Staff then signed and self-assessed their competency against each item (senior managers confirmed with the Health and Care Professions Council that registered healthcare staff e.g. physiotherapists, were able to do this). They were then able to identify who amongst them had specific skills, but also where they had gaps in specialist provision and where training needs could be identified.

From the diagnostic work, small teams of clinical staff worked together to create 'condition-oriented guidelines' for four of the most commonly referred rehabilitation needs (the service receives approximately 150 referrals per week). These are falls, oncology/ palliative care, dementia/ cognitive impairment and Parkinson's disease.

These guidelines provide a paper-based framework of assessments and interventions which demonstrate the level of service patients can expect to receive, regardless of who manages their clinical need. They are commenced by the clinical staff at point of referral and kept in the patient notes.

The benefits of this approach include:

- A clinical prompt/ checklist for staff
- Consistency of assessment and treatment for patients across all teams in the locality
- A standard measure of care that each patient can expect to be provided with
- Confirmation that evidence-based assessments and practices are followed and given
- A competency framework which can also be used as a training needs analysis
- A register of specialist skills which can be drawn upon for individual patient need

In 2013, the guidelines were reviewed. As part of business continuity the assessment and interventions were further categorised down into essential and desirable – in the event of extreme staff shortages. In addition new guidelines are also underway for stroke and breathlessness.

CASE STUDY 9

Impact

The guidelines have a number of benefits (listed above) but their impact cannot be demonstrated through traditional examples, such as reduced admissions or cost-effectiveness (although the cost to produce was met within the existing capacity of the service). The impact is equality and quality for patients who, but for the guidelines, may have received different care depending on where they live. Before the guidelines it is impossible to quantify the level of variation which may have existed, but it can be asserted that variation amongst patients where clinicians have used the guideline is now minimal.

In addition, interest from other Trusts around the country prompted a marketing event in 2014 which may provide additional income for the service.

Challenges

- Staff who were involved in researching, evidencing and creating the guidelines were incredibly enthusiastic about their use, however other team members who had less input into their creation were less motivated to use them in practice
- The implementation was challenging as no electronic records exist and success was reliant on staff filling in paper forms and including them in patient records
- Innovative ways to ensure staff continue to use the condition-oriented guidelines have to be created, for example rotating the responsibility for regular review

TOP TIPS

- Ensure you have organisational support for proposed changes from the beginning
- Do not underestimate the time it takes to review evidence, write up new guidelines and then implement them into working practice
- Involve operational clinical staff in the creation of clinical guidelines as much as possible to ensure ownership and buy in

Contact

Debra Maloney,
Community Rehabilitation Team Manager
Email: debra.maloney@nhs.net
Tel: 07825144685

CASE STUDY 10

Staffordshire and Stoke on Trent Partnership NHS Trust

Audit Ability: Specialist nursing and therapy services for people with progressive neurological conditions

Context

Thirty years ago a consultant physician at Queen's Hospital, Burton-on-Trent, had a vision to offer a case management service for local people aged between 16 and 65 with long-term complex physical conditions, to ensure their needs were met in a timely way and that their care was not 'forgotten' in the system.

A team of healthcare professionals were brought together and met monthly for lunchtime review meetings, and as a result of this approach one full-time (funded) position was split between an occupational therapist and physiotherapist to provide active rehabilitation.

Action

In 2005 a business case for funding was approved which transformed the service into a specialist nursing and therapy team for people with progressive neurological conditions. The provision of care was moved from the local acute Trust to the community and the current team operates across East Staffordshire (population of approximately 135,000) and parts of South Derbyshire.

Today the Staffordshire and Stoke on Trent Partnership NHS Trust 'Adult Ability' team consists of ten staff (including multiple sclerosis and Parkinson's disease clinical nurse specialists, physiotherapists and occupational therapists, a support worker and team administrator) working with a case load of around 600 patients with a range of different conditions, such as Parkinson's disease, multiple sclerosis, Huntingdon's disease and Motor-Neurone disease.

Self-management is intrinsic to the philosophy of care provided by the team and their key principles are:

- Person centred assessment and treatment (physical, cognitive, psychological, emotional)
- A restorative approach – rehabilitation targeting neurological impairment with a goal of improving deficit or maintaining existing function
- Compensation strategies – changing approach, techniques or behaviours to accommodate deficits and manage difficulties
- Environmental modifications
- Encouraging participation
- Life style management
- Liaison with other services – statutory and voluntary

The service operates Monday to Friday 8.30am to 4.30pm. Referrals are normally received through GPs (19 surgeries in the locality) or hospital-based neurologists, and are triaged on a needs basis - with the most urgent cases seen within five to seven working days. Care is provided from diagnosis through to end of life (for adults aged 18 years and over). Once an episode of intervention is complete the service user can re-activate further interventions or advice as required via a single point of access.

Patients are seen at home, in clinic-based settings, at work, or wherever difficulties may occur. Members of staff also run a number of group education and physical fitness sessions in different venues around the locality. Outcomes are measured and reported back to the referring GP (where relevant). Once a year every practice in East Staffordshire is offered a case review of their patients with members of the team visiting surgeries to discuss individual cases. This helps maintain a positive relationship with local referrers and enables them to track the progress of their patients.

Impact

- Annual service user audit from last year revealed 93% of respondents rated the quality of care as good or very good
- The West Midlands Quality Review for Long-Term Conditions from 2013 stated:
  - The Adult Ability Team provided good, integrated care for people with progressive neurological conditions
  - There was a strong focus on keeping people out of hospital and good links with the hospital-based service for discussion of patients' needs

CASE STUDY 10

Challenges

- Changing NHS landscape - four different operating Trusts in nine years since the business case was approved has meant constant re-profiling of procedures, as well as 're-marketing' of the service and building new relationships for information sharing – whilst maintaining a good service for users
- Certain progressive neurological conditions (multiple sclerosis and motor-neurone disease) are predicted to increase - this will impact on delivery of care without further investment[23]

TOP TIPS

- Interdisciplinary teams (as opposed to multi-disciplinary teams) who work together as professionals help the patient receive seamless delivery of care from the service
- A community-based setting, although rare for this type of service, ensures that people have care delivered within their normal setting (home environment) in order to be most effective
- Engagement with commissioners is important, especially when structures change

Contact

Pam Bostock, Consultant Occupational Therapist
Email: pam.bostock@nhs.net
Tel: 01283 507143

[23]Neurological Alliance http://www.neural.org.uk

CONCLUSION

This paper has presented a collection of case studies which represent a number of different rehabilitation services and service models from around England.

Within the existing case studies it is evident that there is much good practice although some of the innovation described is at a relatively early stage of inception. Therefore, the data from these services should continue to be monitored in order to provide long-term evidence of improvement in patient outcomes as well as evidence of cost-effectiveness.

It is also recognised that there are many examples of rehabilitation which are not featured, which could aid other services in finding solutions to common barriers to improvement.

Potential gaps in good practice examples:

- Rehabilitation transition from young people to adults
- Integrated mental health care within rehabilitation models
- Rehabilitation prescription approach for the whole recovery pathway
- Integration of hospital and community rehabilitation teams
- Role of a rehabilitation co-ordinator
- Vocational rehabilitation service

If you have any examples on any of these areas, or any other examples of service redesign and improvement of rehabilitation services which you may have been involved in, you can post these on the Improving Adult Rehabilitation Services Community of Practice[24] NHS Networks website.

We hope these case studies provide helpful learning and inform dialogue for those commissioners and providers looking at their current models of rehabilitation provision.

[24]http://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services

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South Cheshire Clinical Commissioning Group

South East London Regional Amputee Service and Guy's and St Thomas' NHS Foundation Trust

South West Commissioning Support Unit

Staffordshire and Stoke on Trent Partnership NHS Trust

The Dudley Group NHS Foundation Trust

APPENDIX A

Categories of need for people requiring rehabilitation

'Specialised' rehabilitation services were out of scope for this review. These are tertiary high cost/low volume services, which provide for patients with highly complex rehabilitation needs following illness or injury that are beyond the scope of their local and generalist specialist service.[25] They are commissioned nationally by NHS England and are defined as predominantly 'Level 1' (and some 'Level 2' for Category A patients), according to the British Society of Rehabilitation Medicine's description of how rehabilitation services are currently organised and delivered within the UK.[26]

IN SCOPE

Within each locality (Level 3)
Local non-specialist rehabilitation services, which include generic rehabilitation for a wide range of conditions, provided in acute, intermediate care and community facilities or other specialist services (e.g. stroke units). These include:

- Level 3a services: Other specialist services led or supported by consultants in specialties other than rehabilitation medicine - eg services catering for patient in specific diagnostic groups (eg stroke) with Category C needs; therapy / nursing teams have specialist expertise in the target condition
- Level 3b services: Generic rehabilitation for a wide range of conditions, often led by non-medical staff, provided in acute, intermediate care and community facilities, for patients with Category D needs.

Local (district) specialist rehabilitation services (Level 2)
Led or supported by a consultant trained and accredited in rehabilitation medicine, working both in a hospital and community setting. The specialist multi-disciplinary rehabilitation team provides advice and support for local general rehabilitation teams. These include:

- Level 2a services: Led by consultant in rehabilitation medicine serving an extended local population of 600,000 to 1 million people, mainly for those areas which have poor access to level 1 services. Level 2a services take patients with a range of complexity, including Category B and some Category A with highly complex rehabilitation needs
- Level 2b services: Led or supported by a consultant in rehabilitation medicine, these services predominantly provide for patients with Category B needs, and tend to cover a population of 250,000 to 500,000.

OUT OF SCOPE

Tertiary specialised rehabilitation services (Level 1)
High cost/ low volume services provided for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. These are normally provided in coordinated service networks planned over a regional population of 1-3 million through collaborative (specialised) commissioning arrangements.

[25] www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-d/d02/
[26] British Society of Rehabilitation Medicine (2010), Levels of specialisation in rehabilitation services
Available at: www.bsrm.co.uk/ClinicalGuidance/Levels_of_specialisation_in_rehabilitation_services5.pdf

Where patients receive their rehabilitation depends on their identified and assessed level of need. As outlined by the British Society of Rehabilitation Medicine (BSRM), there are four identified categories of need in relation to rehabilitation. These are:[27]

Category A patients	Patients with highly complex rehabilitation needs who require specialised facilities and a higher level of input from specialised staff. Require coordinated, interdisciplinary interventions from 4 or more therapy disciplines in addition to specialist rehabilitation medicine/nursing care in a rehabilitative environment with programmes typically lasting 2-4 months or longer. Patients are treated in a specialised rehabilitation unit (i.e. a Level 1 unit).
Category B patients	Patients have moderate to severe physical, cognitive and/or communicative disabilities which may include mild multi-behavioural problems. These patients may also have medical problems which require ongoing investigation/treatment. These patients require rehabilitation from expert staff in a dedicated rehabilitation unit with specialist facilities. Typically these patients require a 1-3 month rehabiltation programme, but up to a maximum of 6 months providing this can be justified by measurable outcomes.
Category C patients	Patients requiring specialised rehabilitation in relation to specific diagnostic groups (e.g. stroke). They may be medically unstable. Patients typically require rehabilitation interventions involving 1-3 therapy disciplines in programmes lasting up to 6 weeks. Patient goals are typically focused on restoration of function/independence and coordinated discharge planning with a view to continuing rehabilitation in the community. Services are delivered by therapy and nursing teams with specialist expertise in the target condition. Services may be led by consultants in specialties other than rehabilitation medicine (e.g. stroke).
Category D patients	Patients with a wide range of conditions but who are usually medically stable. Patient goals are typically focused in restoration of function/independence and coordinated discharge. These patients require less intensive rehabilitation in relatively short rehabilitation programmes (6-12 weeks), planning with a view to continuing rehabilitation in the community if necessary.

[27]British Society of Rehabilitation Medicine (2010), Levels of specialisation in rehabilitation services
Available at: www.bsrm.co.uk/ClinicalGuidance/Levels_of_specialisation_in_rehabilitation_services5.pdf

APPENDIX B

Rehabilitation services in the context of existing national programmes

- **NHS Services, Seven Days a week Transformational Improvement Programme (SDSIP)**
  The delivery of seven day services across England is a priority for NHS England. The SDSIP programme was launched in November 2013, supporting the Seven Day Services Forum Review undertaken by Sir Bruce Keogh. Delivering rehabilitation services seven days a week is an underpinning principle of the rehabilitation review.
  www.nhiq.nhs.uk/resource-search/publications/nhs-imp-seven-days.aspx

- **Integrated Care and Support Programme**
  Integrated Care and Support: Our Shared Commitment (2013) published by the National Collaboration for Integrated Care and Support aligns well with rehabilitation. It offers opportunities for improvements in the design, delivery and workforce for rehabilitation within the context of integrated care and support. It particularly highlights the need for improving the experience and outcomes for patients and the freedoms and flexibilities in the system to enable local areas to take forward models of integrated care and support.
  www.gov.uk/government/publications/integrated-care

- **Better Care Fund**
  The fund provides an opportunity to transform care so that people are provided with better integrated care and support. It encompasses a substantial level of funding and aims to help deal with demographic pressures in adult social care. Plans and mechanisms to support joint funding can help to facilitate coordinated network of health, public health, social care and local authority services. This can help to eliminate gaps in provision and enable better use of resources by reducing duplication and achieving services with greater economies of scale. This may be useful to support new rehabilitation and creative workforce modelling and is particularly relevant to prehab and self-management parts of the rehabilitation pathway.
  www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

- **Pioneers programme**
  Rehabilitation services, which span delivery across a number of care settings and organisational boundaries, should be delivered in a coordinated, integrated way. A large proportion of rehabilitation care also focuses on on-going care for people with one or more long-term condition. As such, rehabilitation work will need to be effectively aligned within the Integrated Care Support Pioneers Programme (14 pilot sites) to ensure a joined up approach.
  www.england.nhs.uk/2013/11/01/interg-care-pioneers

- **Long Term Conditions Year of Care Commissioning Programme**

1. The programme is developing a national currency framework with seven early implementer sites for people with two or more long-term conditions. From April 2014 the early implementer sites will be shadow testing new models of care delivery and their associated commissioning and contracting arrangements.
2. A recovery, rehabilitation and reablement Clinical Audit was undertaken as part of the programme to identify whether people were discharged home for timely community RRR. The analysis demonstrates that a 20% reduction in acute bed length of stay continues to be achievable as 30% of those included in the audit had delayed discharge due to awaiting assessment and review of discharge planning.
   www.icase.org.uk/pg/groups/88229/

- **Personalised health budgets**

  Progress within social care around personalisation of budgets creates a framework that supports care planning, self-management and rehabilitation prescriptions. Islington Council is putting co-production at the heart of its approach to 'Making it Real'. A Making it Real Board is being established that will include a range of stakeholders including the NHS, voluntary sector, people who use care and support services, and family carers working together to support effective implementation of personal health and care budgets.
  www.personalhealthbudgets.england.nhs.uk/

APPENDIX C

Glossary of abbreviations

A&E	Accident and Emergency
BACPAR	British Association of Chartered Physiotherapists in Amputee Rehabilitation
BCF	Better Care Fund
BNSSG	Bristol, North Somerset and South Gloucestershire
CCG	Clinical Commissioning Group
COG	Condition Oriented Guidelines
COPD	Chronic Obstructive Pulmonary Disease
EMIS	Egton Medical Information Systems
HoE	Heart of England NHS Foundation Trust
IARS	Improving Adult Rehabilitation Services
ICARES	Integrated Care Services
JETS	Joint Emergency Teams
NICE	National Institute for Health and Care Excellence
PPC	Post-operative pulmonary complication
PR	Pulmonary Rehabilitation
RCP	Royal College of Physicians
RCS	Rehabilitation Complexity Scale
ROLC	Rehabilitation for Operated Lung Cancer
RRR	Recovery, Rehabilitation and Re-ablement
SDSIP	Seven Day Services Improvement Programme
SEL	South East London
SIGN	Scottish Intercollegiate Guidelines Network
SoTW	South of Tyne and Wear
SSND	Specialised Services National Definition
SWB	South West Birmingham Hospitals NHS Foundation Trust

REFERENCES

Specialist Services Guidelines

British Association of Chartered Physiotherapists in Amputee Rehabilitation
http://bacpar.csp.org.uk

Association of Physiotherapists in Cardiac Rehabilitation
www.acpicr.com

Scottish Intercollegiate Guidelines Network
www.sign.ac.uk

National Institute for Health and Care Excellence
www.nice.org.uk

Royal College of Physicians
www.rcplondon.ac.uk

Chartered Society of Physiotherapists
www.csp.org.uk

British Society of Rehabilitation Medicine
www.bsrm.co.uk/index.htm

British Thoracic Society
www.brit-thoracic.org.uk

British Association for Cardiac Rehabilitation
www.bacpr.com/pages/default.asp

British Geriatric Society
www.bgs.org.uk

Improving Adult Rehabilitation Services
www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/#COP

Royal College of Psychiatrists
www.rcpsych.ac.uk/healthadvice/treatmentswellbeing/rehabilitationservices.aspx

Medical and Community Rehabilitation Models

Social Care Institute for Excellence
www.scie.org.uk

World Health Organisations
www.who.int/disabilities/en

National Institute for Health and Clinical Excellence www.nice.org.uk

Royal College of Physicians
http://www.rcplondon.ac.uk

Improving Adult Rehabilitation Services
www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/#COP

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