NHS England

NHS England Improving Rehabilitation Services Programme

Regional Report – London

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Foreword

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1.1 Foreword

This document is one of four regional reports written by the four NHS England Regional Rehabilitation Leads in 2015. The remit of these documents were as torchbearers for the adoption and dissemination of good practice and innovation in rehabilitation as well as inclusive Allied Health Professional (AHP) leadership.

This document was written by the then London regional rehabilitation lead Dr Karen Robb, and it represents a "rehabilitative" snapshot of London at a point in time. The report captures knowledge, expertise and good practice and makes recommendations so that we can embed high quality rehabilitation at the heart of London's commissioning intentions.

London is a fast paced environment where things seldom remain the same and the rehabilitative setting is no different, since this document was written, Sustainability & Transformation Plans (STPs) have developed in the five sub-regions of London. However, some of its recommendations are still as valid today as they were last year, earning its place in the annals of rehabilitation for its ambition, frankness and focus on system collaboration and quality improvement.

Dr Robb's work, along with that of the other 3 regional leads , was seminal in that the vision, perseverance and input was a catalyst for a more joined up approach to rehabilitation and a focus on consolidation of practice and helped highlight the need to achieve more consistency in service delivery and best practice, and helped shape the subsequent NHS England Rehabilitation Commissioning Guidance (https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf) as well as feeding into the Chief Allied Health Profession Officer's national mandate for the Allied Health Professions.

How this document can help you

The document highlight some of key challenges facing rehabilitation service delivery in London and offers recommendations for how to improve the quality of service delivery and enhance patient care. It remains a useful historical reference point for commissioners, clinicians and managers to aid their understanding of the principles and expectations for good rehabilitation services.

This document presents the scoping activities of the London Rehabilitation Lead over 2015/2016.

1 Introduction

1.1 Definition of Rehabilitation

The Improving Rehabilitation Services programme has developed the following working definition:

"Rehabilitation is the development, 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 education/training and the workplace where appropriate".

This working definition was agreed at the beginning of the programme and has been refined to reflect its ongoing development. There are many services specifically named as rehabilitation services which immediately recognise their inclusion in the Improving Rehabilitation Services programme. However there are also many services that provide interventions and care that falls within the above definition that do not recognise their role as undertaking rehabilitation. Whilst there is no need to rename these services it is vital that the service providers, clinicians and commissioners of these services recognise the contribution they make to the rehabilitation of their service users and that they are included in the scope of the rehabilitation services available locally.
The Improving Rehabilitation Services Programme includes the whole breadth of services which fall into the above definition in its remit.

1.2 The Vision

Rehabilitation will be key to every episode of care.

It will maximise mental and physical health, independence and occupation.

Rehabilitation is everyone's business.

1.3 Background

In 2012 the NHS Medical Director, Sir Bruce Keogh, asked the Chief Allied Health Professions Officer (CAHPO) to establish if there was case of need to improve adult rehabilitation services. The subsequent review established that although there were areas of good practice there was variation in adoption and dissemination and people using services and clinicians wishing to make referrals did not know what services were available and how to access them. The Improving Rehabilitation Services programme (IRS) was established to address the case of need that was identified. Subsequently NHS England appointed John Etherington as National Clinical Director for Rehabilitation and Recovering in the Community and together with the CAHPO he has established the NHS England Rehabilitation Delivery board. This board sets the strategic direction for the programme and oversees the delivery of the work plan for the programme.

The board's priorities for 2014/15 are:

1. Rehabilitation to enable people to remain in or return to work and meaningful activity

2. Rehabilitation to improve the quality of life for people with Long Term Conditions

The board has established the following working groups to support and deliver against these priorities:

- Commissioning Guidance

- Commissioning Levers and Incentives

- Rehabilitation for Economic Growth

- Children and Young People's Rehabilitation Services

Further work has been undertaken which includes:

- Commissioning the Improving Rehabilitation Services Community of Practice (IRS COP).

The community of practice is provided by the NHS Clinical Soft Intelligence Service and hosted on NHS Networks. It provides via an independent platform a forum for discussion and debate for all those concerned with improving rehabilitation service. Community members are encouraged to submit "snapshots" to describe any service improvement and development projects they are or have undertaken to share best practice and spread adoption. In the last six months the community have been asked to respond to specific soft intelligence questions to further understand the barriers and enablers to improving rehabilitation services. NHS CSIS has also delivered 6 webinars for members and the wider rehabilitation community in collaboration with the NHS England team. Further information including the collated snapshots (by region), analysis of the soft intelligence, and webinar recordings can be found at http://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services

- Development of "Principles and Expectations for good adult rehabilitation" in response to the original review. Following extensive stakeholder engagement this document describes what good rehabilitation should look like and offers a national consensus on what service users should expect from services. The principles and expectations are referenced in NHS Wessex Strategic Clinical Networks. Rehabilitation Reablement Recovery: Quality Guidance Document[9].

- Following the initial review in 2013/4 which focused on adult rehabilitation services there was recognition that CYP rehabilitation services required separate attention. This is now being addressed in a scoping project to answer the question "is there a case of need to improve children and young people's rehabilitation services?" The scoping project will report to the board in May 2015 and make recommendations on the priorities for improvement.
  - Initial evaluation of the system wide economic benefits of rehabilitation including, social care, DWP department for education and Ministry of Justice.

2 Regional Rehabilitation Lead Posts

2.1 Remit

The initial review of adult rehabilitation services identified that there was a lack of adoption and dissemination of good practice and innovation in rehabilitation services leading to variation in service delivery. The report also identified transformational leadership was needed at all levels of the system to drive improvement and to raise the profile of the contribution of rehabilitation services to achieving optimal outcomes for service users. To address this issue a key element of the programme's work in 2014/15 has been to spread adoption and dissemination of good practice. To enable this, and in recognition of the necessary leadership to achieve this, a Rehabilitation Lead post was established in each region of NHS England and as part of the national leadership team.

In October 2014, the programme appointed four regional rehabilitation leads (6 month contract) to provide system leadership to deliver transformational change to rehabilitation and re-ablement services at regional level. A key element of the work has been to promote adoption and dissemination of good practice and innovation in rehabilitation services to reduce variation.

The Regional Rehabilitation leads provide professional and clinical expertise across each region, developing and adopting strategies and management processes to improve rehabilitation services ensuring alignment with the activity of the organisation at national and regional levels.

- Creating, supporting and enabling alignment of strategy change across the organisation.
- Developing and communicating the vision for rehabilitation and work with others to enable the operational detail.
- Engaging with key strategic regional and national stakeholders including patients and the public to inform development of strategies and policies.
- Working collaboratively with key stakeholders to develop best practice to meet the needs of the organisation and all its stakeholders.
- Working with providers and clinical experts in an effective manner to deliver strategies and processes to meet developing needs.
- Provide subject matter expertise towards the development of best practice methodologies, policies and strategies.

The Rehabilitation work programme was led by the Rehabilitation Programme Lead and the regional leads worked closely with and provided support to this role to enable delivery of transformational change.

2.2 Objectives

Based on the remit described above the Regional Rehabilitation Leads have had the following objectives to achieve whilst in post.

1. Identify service models of good practice in rehabilitation – assessed against the principles and expectations for good rehabilitation services and ensure regional collation of information and self-assessment on models of good practice.
2. Identify effective methods for adoption and dissemination of good practice both in the region and nationally via other RRLs and in liaison with NHS CSIS and Improving Rehabilitation Services Community of Practice (IRS COP).
3. Support further adoption and dissemination with in the region making the most effective use of resource identified to undertake this.
4. Promote participation in the IRS COP and submission of snap shots of service innovation/improvement.
5. Engage with LETB's in the region and:

   a. Identify lead for workforce planning for rehabilitation
   b. Raise profile of need to consider workforce planning to support new models of service delivery
   c. Contribute to the planning for a potential rehabilitation workforce workshop

6. Engage with regional SCNs, AHSNs and clinical senates and create list of contacts for each.
7. Make contact with CCGs in the region and where possible identify contacts for commissioning of rehabilitation services.
8. Identify current service data collection and service evaluation (including audit, research and economic evaluation) and support local implementation of pilots where appropriate.

3 Regional Context

The NHS England London region commissions more than £15bn of services for the 8.17 million people living in the capital. Although the London region is more geographically compact than the other 3 regions there is significant complexity due to its size and scale. The region incorporates 32 CCGs; 33 Local Authorities; 16 acute NHS trusts, three mental health trusts, two community trusts and 18 NHS foundation trusts; 3 LETBs (Health Education North West London, Health Education South London and Health Education North Central and East London), 3 AHSNs (UCL Partners, Imperial College Health Partners and Health Innovation Network South London) and 6 SCNs (Cardiovascular; Maternity; Children; Mental Health; Dementia and Neuroscience). The London Leadership Academy has also outlined that London has particular challenges as the capital has, *"…the largest number of teaching hospitals in the country, proportionally the lowest number of Foundation Trusts and a significant number of financially challenged organisations"* [1].

In October 2014, The NHS England Five Year Forward View[2] was published which was timely for the Improving Rehabilitation Services programme and the commencement of the Regional Rehabilitation lead role. Rehabilitation delivers the

prevention, public health services and integrated out-of-hospital care that the Five Year Forward View demands and is key to delivering transformational change to deliver better outcomes for citizens.

There are a several workstreams within London which are important catalysts and enablers for improvements in rehabilitation. Unlike other regions, London has an NHS England Regional Allied Healthcare Professionals (AHP) Lead (Andew Nwosu) who has been in post for 11 months and chairs a pan-London AHP Advisory Group which meets quarterly. This group incorporates a broad range of stakeholders and is focused on raising the profile of the Allied Health Professions and highlighting the value of AHP inclusion in outcome-based commissioning intention, system transformation and integrated person-centred care.

The recent publication of the London Health Commission Report "Better Health for London"[3] has set a clear strategic direction for London and is an important driver for rehabilitation due to its strong focus on Prevention and Healthy Living. Delivering this ambitious plan for London will require a better awareness of the public health dimension of rehabilitation services; recently outlined by the Royal Society for Public Health[4]. There is potential for better health outcomes for Londoners if rehabilitation is fully embedded into every episode of care and Allied Health Professional (AHPs) 'make every contact count'.

A significant programme of work is underway in London to transform community services and this has involved an innovative methodology called 'crowdsourcing' and has involved extensive stakeholder engagement from 100+ organisations and representing all 32 CCGs. The programme has declared that*," A community-led revolution in health and social care will transform the health and well-being of London"* and there are 4 pledges at the heart of this work; to get personal; to focus on outcomes; real leaders, happy workers and to make boundaries invisible. For more information see: http://www.transformldn.org[5]

Another significant piece of work is underway to transform primary care in London with the original report[6] published in November 2013 and an event was held on 26th November 2014 with a wide range of stakeholders to help plan the future direction. This work is ongoing.

Finally, two of the new 'vanguard sites' for the New Care Models Programme are situated in London. They are Tower Hamlets Integrated Provider Partnership (Multispecialty Community Provider) and Sutton CCG (Enhanced health in care homes).

All of these projects and workstreams in London offer opportunities to develop and enhance the rehabilitation pathway and improve outcomes for citizens.

4 Delivering Against Objectives

The RRL has worked towards 8 key objectives and the progress that has been made towards each of these will now be discussed.

1. **Identify service models of good practice in rehabilitation – assessed against the principles and expectations for good rehabilitation services (P&Es) and ensure regional collation of information and self-assessment on models of good practice.**

Identifying models of good practice in rehabilitation was a key focus for the Regional Rehabilitation Leads (RRLs). Previous work by NHS Improving Quality (NHSIQ)[7] had identified 2 exemplar services in London, a rapid response service for older adults and an integrated amputee rehabilitation service. Beyond this however, no work had been done to identify good practice in London, collate this information and benchmark it against emerging 'Principles and Expectations for Good Adult Rehabilitation (P&Es) (see Appendix 9.2). This section describes two separate but related activities which the RRL in London undertook to both identify good practice and benchmark services against the P&Es.

a) Benchmarking services against the principles and expectations for good rehabilitation services (P&Es)

Between November 2014 and March 2015 the Regional Rehabilitation Leads (RRLs) undertook a project to collate information on how well, and how easily, local rehabilitation services could benchmark themselves against the Principles for Good Adult Rehabilitation. This project was also a way of identifying service development opportunities and barriers to development as well as facilitating sharing and dissemination of good practice. Services were not formerly screened for quality before taking part in this exercise however the RRL for London worked with services who volunteered to support this work. The 'Expectations for Good Adult Rehabilitation' were not used for benchmarking as they are written from a service user's point of view and the administrative effort needed to get service user feedback was not possible within the timeframes of this project. A template was designed (see Appendix 9.1) to enable services to provide evidence of how they were meeting the principles as well as the service development opportunities they identified and the barriers to moving these forward. The RRL gained support for this work through the AHP Advisory Group and other contacts made via telephone calls and visits with key stakeholders. The RRL was available to support services with completion of the templates and on many occasions provided comment on a first draft to facilitate more complete information to be provided. Generally, there was strong engagement with this project and a total of 20 templates were secured from services across London. Eight templates were secured from one organisation alone. The templates represent 3 NHS Acute Trusts and 7 NHS Foundation Trusts and a broad diversity of services are represented. The teams who completed the templates are shown in Table 1 (N.B. An asterisk next to the name of the team indicates that a site visit also took place for this organisation, 2 asterisks denote a specific visit was made to the team described in the template).

The data in Table 1 represents a mix of speciality areas, professions and rehabilitation settings. Most teams provided good data on their core service models and there is a good mix of in-patient and out-patient rehabilitation services with only 2 services providing domiciliary rehabilitation. The majority of services have a service specification (16/21) but do not operate a 7-day rehabilitation service (20/21). There are no integrated teams represented although the RRL has gathered information on integrated services via other means, see later in the report
The quality of evidence provided as evidence against the principles varied greatly with a few services choosing not to complete this section and focus on the development opportunities and barriers instead. Most services provided substantial data on how they were meeting the principles of good rehabilitation with many clearly spending time on this section and giving comprehensive coverage. Several services struggled initially with identifying service development opportunities and barriers and completed data in either one section or the other making interpretation difficult. Following discussion with the RRL in London all of these services submitted a second draft with more detailed information. Overall, some key themes for service development have been identified and they include:

- Data collection including Patient Reported Outcome Measures (PROMS) and evidence of social and economic impact of interventions. This will be discussed more on page 23.
- Engagement with service users and carers including co-creation of services
- Prevention and early intervention e.g. prehabilitation
- Patient information
- Patient-centred goals
- Integrated working
- Clinical leadership
- Access to services including 7 day working, self-referral, single point of access, long-term follow up
- Extension to current services to include e.g. more conditions in referral criteria for self-management programmes, satellite clinics
- Continuing Professional Development (CPD) opportunities
- Access to IT and digital technologies
- Access to cognitive/psychological assessment for service users
- Research & Development and collaboration with Higher Education Institutions (HEIs) and research staff
- Networks/Networking
- Partnership working with commissioners.

Team	Location	Provision: In-pt/ O-pt/Home	Service specification (Y/N)	7 day therapy service (Y/N)	Staff groups	Integrated team (Y/N)
Community Neuro team	Community Locations, Domicilary	O-pt & home	Y	N	PT; SALT; OT; Psychology; CNS; Case Manager; Admin; RA	N
* Acute neurological step-down team	In-patient ward	In-pt	Y	N	PT; OT; SALT; RA; Dietician; medical and nursing	N
* In-patient acute neurological rehab team	Hospital wards	In-pt	Y	N	PT; OT	N
Neurological rehabilitation unit	In-patient ward	In-pt	N	N	PT; OT; SALT; Psychology; Dietetics; medical and nursing	N
* Stroke Unit and HASU rehab team	Stroke Unit and HASU	In-pt	Y	N	PT; OT	N
* Acute neurosciences rehab service	Neurosciences wards & Out-patient clinics	In-pt & O-pt	Y	N	PT; OT: SALT	N
* Surgical Occupational Therapy team	Hospital wards	In-pt	N	N	OT	N
Orthoptic stroke service	Out-patient clinics	O-pt	Y	N	Orthoptist	N
* Orthopaedic occupational therapy team	Hospital wards	In-pt	N	N	OT	N
* Major trauma therapy team	Major trauma wards	In-pt	N	N (but on-call PT for respiratory)	Acute rehabilitation	N
* Elderly rehabilitation unit	Older peoples wards	In-pt	Y	Y	PT; OT	N
Adult musculoskeletal service	Community clinics and GP surgeries	O-pt	Y	N	PT; podiatry	N
Mental health rehabilitation team	In-patient units	In-pt	Y	N	OT; activity co-ordinators; nursing and medical; HCA; psychology; arts therapy;	N
Specialist cancer rehabilitation team	In-patient wards and Therapy department	In-pt & O-pt	Y	N (but on-call PT)	PT; OT; SALT; Dietetics; lymphoedema therapy; complementary therapy; appliances officer	N
Oncology therapies	In-patient wards &	In-pt & O-pt	Y	N (but on-call	PT; OT; RSW	N

team	Rehabilitation department			PT)		
Cancer survivorship programme	Physiotherapy gym	O-pt	Y	N	PT: psychology; dietetics; medical	N
** HIV/AIDS Rehabilitation	Physiotherapy gym	O-pt	N	N	PT	N
Renal rehabilitation team	Rehabilitation Unit	O-pt	Y	N	PT	N
Pain management programme	Hospital	O-pt	Y	N	PT; OT; Psychologist; assistant psychologist	N
** Osteoarthritic pain self-management course	Physiotherapy department	O-pt	Y	N	PT	N
Long-term conditions podiatry team	Community clinics; Out-patient clinics; Domiciliary	O-pt & Home	Y	N	Podiatry	N

Table 1*: A description of services that completed the template.*
Abbreviations: PT (physiotherapy); OT (occupational therapy); SALT (speech and language therapy); CNS (clinical nurse specialist); RA (rehabilitation assistant); HCA (healthcare assistant); RSW (rehabilitation support worker)

The two consistent barriers to service development that were highlighted are:

- Time
- Resource including staffing, money.

Other barriers included:

- Environmental e.g. lack of space for expansion
- Limited buy-in from senior management and/or competing priorities
- Poor understanding of rehabilitation by CCGs
- Prevalent biomedical model of care, as opposed to the more all-encompassing biopsychosocial model
- Lack of networking opportunities
- No access to Service Improvement teams
- AHP voice is small compared with nursing/medicine
- Lack of strategic and clinical leadership in AHPs.

Findings from this work suggest that with a little refinement, the template will be a useful tool for future benchmarking and has highlighted some key themes that will be useful in guiding future work in London. It may be useful to repeat this exercise using the 'Expectations of good rehabilitation' as it will focus on service users' views and what matters most to them. Interestingly two CCGs in London have suggested that this benchmarking against the Expectations would be of great interest to them and both would be willing to engage with future work. As better engagement with service users has also been identified as a key area for development (see above) this could be a useful follow-up exercise to complement the work already done. Overall, it seems important to build on the momentum generated and to continue this improvement work in some way. This could be achieved through the development of a 'Pan-London Service Improvement Forum' to bring teams together to focus on transformational change and improving outcomes for patients. This will be discussed further in the recommendations on page 30.

b) Site visits

A range of site visits were carried out when the RRL in London was made aware of good practice, particularly in long-term conditions management and/or return to work. Sometimes the RRL was able to witness the rehabilitation team in operation but the majority of visits involved meeting the rehabilitation team, discussing the service and acquiring more information about how the team operates. During all of these visits, the RRL was able to share a team powerpoint presentation which covered the background to the work and the remit of the RRL roles and encourage the teams to get involved with the Improving Rehabilitation Services Community of Practice (IRS COP), soft intelligence gathering and benchmarking work. It was also a good opportunity to encourage the teams to share their good practice and to put them in touch with others who were doing similar work, or who were facing similar challenges. A brief summary of some key visits is shown below:

- The RRL visited the Oxleas NHS Foundation Trust and Royal Borough of Greenwich Adult Community Services Integrated Rehabilitation Team which was showcased in the NHS Clinical Soft Intelligence publication on sharing

good practice[7] and has led the way in delivering integrated services in London. This was a whole day visit and incorporated a range of teams across different settings. A full review of the service is beyond the scope of this report but a few key aspects have been chosen to highlight. It was clear that the journey to integration has been a challenging one but the key enablers were seen as culture change; co-location of teams; strong leadership; keeping things simple; shared language; shared learning and IT. The 'care navigator' roles appear to be very important and act as enablers for clients to help them fully achieve their goals. These navigators are not healthcare professionals and are fully trained in Motivational interviewing (MI), using solution focused approaches and developing "I-statements" and "I-plans" to ensure all discussions are completely client-centred. A formal evaluation of these roles is underway and although the final report is not yet available, it has been shown that housing is a significant issue for many clients and there is lots of learning about what the voluntary sector can offer. The navigators also play an important role in service improvement as they can identify gaps in service provision which can then be highlighted to CCGs e.g. poor access to exercise on referral or dementia support workers. The Joint Emergency Team is a multi-professional team based at Queen Elizabeth Hospital and focused on preventing unnecessary admissions and facilitating timely discharges. This is an excellent service which is clearly meeting its goals and has good basic data. The RRL made a recommendation that the team review their data and calculate cost-savings to the system as well as data on admission avoidance.

- The RRL visited the ESCAPE Pain Programme at Lewisham Hospital after attending an event hosted by the "Health Innovation Network (HIN)" showcasing the R&D work by Prof Mike Hurley and colleagues and the subsequent spread and adoption of ESCAPE pain. The RRL was able to witness the programme in action as well as to speak to the clinicians and a senior manager. This programme clearly benefits from the strong links with the HIN and utilises valid and reliable outcome measures with good data analysis. The programme appears to be well received by patients and staff enjoy running the programme and are keen to develop it. The RRL was able to offer many suggestions for how the programme could be improved including better networking with other sites delivering the programme and consideration to the social and economic impact of the programme including formally measuring return to work. The team subsequently benchmarked their service using the NHS England template and further development opportunities were identified. Prof Mike Hurley found the liaison with the RRL incredibly helpful and stated,

"Karen Robb visited our department and was extremely supportive and encouraging of our work. However she also gave us several practical advice, ideas and suggestions that have advanced our work, and ways that it could be showcased so that more people are aware of our efforts."

- The RRL visited the Kobler Rehabilitation Class for HIV/AIDS out-patients at Chelsea and Westminster Hospital and was able to witness a class in action as well as meet with clinical and management staff. The class runs twice weekly and is a supported self-management intervention comprising of education and physical activity in the physiotherapy gym. The team have made excellent links with research teams abroad and have a strong

international network of colleagues with whom to share good practice. The team undertake regular audit and service review and are making in-roads into more formal research activities. Although the class appears to improve quality of life in those who attend regularly, the biggest challenge for this service appears to be attendance and adherence. The RRL is keen to do further work with this service on outcome measurement, particularly looking at the economic aspects, including return to work. The RRL was able to put this team in contact with an oncology team at Bart's Hospital who are doing similar work in cancer survivorship and facing similar challenges. What is particularly interesting about the rehabilitation work in HIV/AIDS is the reference to the "Episodic Disability Framework"[8] a conceptual framework to describe the episodic nature of disability that occurs on a daily basis and over the entire life-course of a person living with HIV.

- The RRL visited the Neurosciences Clinical Lead at the Royal Free Neurological Rehabilitation Centre at Edgware Community Hospital and discussed the wide range of services available with a particular focus on the vocational rehabilitation (VR) and supported self-management work. This team performs an annual service review and have good data on outcomes. The team is also growing every year and has an excellent relationship with their CCG. They were among the first in London to trial the 'neuro-navigator' roles and have shown the benefit of these roles in managing the complexity of both patients and care pathways. These roles facilitate speedy transitions between care settings and are important in reducing costs and improving outcomes for patients. These roles appear worthy of wider roll-out. The VR at Edgware Community Hospital service was established in 2011 and is a small multi-disciplinary team which deals with work-related issues. The service is delivering good outcomes for patients with 66% of patients attending re-entering meaningful occupation. The success of this VR service is attributed to it being a local service with local partnerships. Finally, the team have broad expertise in supporting self-management with many staff trained in Motivational Interviewing (MI), mindfulness and groupwork. This means that they are well equipped to meet the changing needs of their local population and deliver on the prevention and public health agenda.

Throughout the benchmarking work and the site visits, the RRL has been sign-posted to many other services who are doing excellent work in rehabilitation and would be worthy of a future visit. Key contacts have been captured and will be important for any future work.

2. Identify effective methods for adoption and dissemination of good practice both in the region and nationally via other RRLs and in liaison with NHS CSIS and Improving Rehabilitation Services Community of Practice (IRS COP).

And

3. Support further adoption and dissemination with in the region making the most effective use of resource identified to undertake this

Promoting adoption and dissemination of good practice has been a key objective for the Regional Leads and within London there are many examples of where this is already working well and where models could be replicated. There is also evidence of where services are clearly struggling to both share the good work they are already undertaking and/or learn from other services that are doing similar work; whether those services are in a similar or different speciality area. It is very clear that services are 'not talking to each other' and a vital role of the RRL in London is to bring people together to avoid duplication of effort and disseminate good practice widely. There are many examples of where the RRL in London has been able to do this and the following examples illustrate the importance of having a regional lead with a 'helicopter view' of the system:

Example 1: The RRL in London was approached by the Stroke Clinical Leadership Group (CLG) to assist with the development of patient information relating to Vocational Rehabilitation, This had been identified as a priority area for Stroke and is equally, a priority area for the IRS Programme. The RRL in London was able to connect the Stroke CLG with the Working through Cancer Programme lead at Macmillan Cancer Support who has developed excellent patient information over many years and was able to share this information and advise on how it could be adapted for a different cohort of patients. This work is ongoing.

Example 2: The RRL, working in conjunction with the NHS England AHP lead was able to widely disseminate the recently published Wessex Strategic Clinical networks' 'Rehabilitation, Re-ablement and Recovery Quality Guidance document'[9]. This is an important document being one of the first regional and national documents that is not disease specific but focused on what local stakeholders have identified as important. It aims to provide commissioners and providers with a means by which they can develop and benchmark their local services. There is great potential to develop similar work in London. Other resources that have been disseminated are the 'Improving Rehabilitation Services Community of Practice 2nd compilation of snapshots'[10] and the Transforming Community Services in London Declaration[5], amongst others.

Example 3: The RRL in London participated in 2 webinars organised by the IRS COP with the key aim of sharing good practice. One of these involved an exemplar Falls and Bone Health service in London led by Bernadette Kennedy, Head of the Integrated Falls and Bone Health Service at St George's University Hospitals NHS Foundation Trust. The RRL interviewed Bernadette for the webinar and focused on the means by which Bernadette had developed an integrated health and social care service to improve quality of life and function in disabled clients attending a Day Centre. The focus was deliberately on the how things were done, and not what was done, to facilitate implementation of best practice. A link to the webinar can be found here: https://www.youtube.com/watch?v=72-SpTMV_YI[11].

Example 4: The RRL was invited to a Rehabilitation workshop at Chase Farm hospital to help model a new integrated rehabilitation pathway across Enfield to enable the CCG to develop a service specification.

Example 5: The RRL liaised closely with the Leads for Rehabilitation/AHPs within both Integrated Cancer Systems in London (London Cancer and London Cancer

Alliance). The priorities areas for rehabilitation have been identified as: improving data and outcome measures; improving R&D; the loss of specialist AHPs and influencing CCGs to improve commissioning across the pathway. London Cancer Alliance (LCA) has recently published a Workforce Mapping report[12] which shows the lack of specialist AHPs operating within LCA. There is also an opportunity to share learning from the impact of a two-day MI course for nurses and AHPs within LCA. London Cancer is due to report on their mapping of rehabilitation service provision at the end of April 2015 and a rehabilitation masterclass is planned to discuss recommendations for future commissioning. There is great potential for the RRL to support these publications/events.

The AHP Advisory Group in London is a vital forum where the importance of AHPs and the vital role that rehabilitation plays in delivering better outcomes for patients is promoted and discussed. It is also a valuable forum for sharing good practice and attendees are encouraged to update the group wherever necessary on key projects that they lead or have involvement with. For example, the most recent meeting was hosted by Suzanne Rastrick, the CAHPO for NHS England and during this meeting the CAHPO gave a full update on her activities and her key influencing work to allow attendees to see the 'bigger picture' and the key policy levers and drivers. There was also a presentation by Viccie Nelson, the Lead for the "Transformation of Community Services' workstream at NHS England which allowed attendees to better understand how AHPs could contribute to this important work. There is great potential for this Advisory group to work with the findings of this report and consider future projects to drive transformational change in rehabilitation in London. These projects should be focused towards key regional and national priorities (as identified in the London Health Commission Report[3] and Five Year Forward View[2]) and could include developing the workforce based on best practice examples.

Good adoption and dissemination already exists where rehabilitation services are working within networks e.g. Trauma or Stroke. This is often due to the presence of AHP leadership roles and regular fora where rehabilitation can be discussed and good practice can be shared. Some examples of good practice are the Clinical Rehabilitation network at University College London Partners (UCLP) hosted by Queen's Square, the quarterly Occupational Therapy Rehab forum in Mental Health and the bi-monthly Health Education North West London (HENWL) AHP meeting.

The IRS COP has identified the following themes as critical for the dissemination and adoption of good practice

- Communication
- Working together
- Developing AND sharing AND applying the evidence base
- Making the evidence accessible
- Aligning objectives for improvement
- Creating a culture for change
- Being active in networks
- Harnessing leadership
- Collaboration not competition
- Developing commissioning solutions
- Adopting new models and behaviours

It is clear that the presence of a RRL post in London has developed some momentum within the region for transformational change. Feedback from stakeholders who have worked with the RRL has identified some key benefits of having this post in the region,

"I think the real advantage is that the regional rehab role gives an opportunity to benchmark current services across a broader area and enables shared learning that is so often lacking within the healthcare environment. Rehab pathways are complex as they by the very nature of the pathway encapsulate a range of providers including health, social care and the voluntary sector and the regional rehab lead has the ability to act as a facilitator to broker some of the challenges that need to be overcome in order to develop the effective partnerships required to provide an effective patient journey" (Fiona Jackson, Hospital Director Chase Farm and Director of Integrated Care).

"Having a national focus on rehabilitation is extremely helpful. Having a focus at the local level is even more helpful because they understand the local context where the local population live and work and clinicians where deliver rehabilitation. They have a unique grasp of the local priorities, pressures, what local factors facilitate and impede rehabilitation, local resources that can be tapped into and the local opinion leaders who should be aware of and can help local initiatives" (Prof Mike Hurley, St Georges University of London and Kingston University)

Further adoption and dissemination of good practice could be promoted by strengthening existing networks and clinical leadership and encouraging new networks to be formed.

4. Promote participation in the IRS COP and submission of snap shots of service innovation/improvement.

The RRL in London considered this an important aspect of her work and has promoted the IRS COP at every opportunity whilst on clinical visits, attending conferences, team meetings and teleconferences etc. The first compilation of snapshots by the NHSIQ included only one snapshot from London, which was extremely disappointing and not representative of the excellent work that was being undertaken in the region. As a result, the RRL in London sent emails to a wide range of stakeholders to remind them of the importance of submitting snapshots to get their service achievements published and promoted nationally. Particular emphasis was placed on services that were 'under the radar' and less likely to consider themselves innovative. As a result, the 2nd compilation of snapshots *(see: https://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/documents/snapshots-updated-feb-2015/view)*[10] featured 9 services in London, representing almost 50% of the total submissions. Interestingly 4/9 submissions were cancer-related and highlight the growing importance of addressing the needs of patients living with and beyond cancer, how cancer is increasingly recognised as a long-term condition and the important role of the voluntary sector in service innovation. Snapshots included:

- Scoping the unmet needs of teenagers and young adults at the University College London Hospital (UCH) Macmillan Cancer Centre.
- Developing rehabilitative services for men with Prostate cancer in North East London, led by Barts Health NHS Trust and St Joseph's Hospice.
- Introduction of a "recovery package' to support self-management at the Royal Marsden NHS Foundation Trust.
- Scoping the types of rehabilitation service used by people with Brain and CNS cancer by London Cancer Alliance.

The other snapshots identified in London relate to neurological rehabilitation and trauma and demonstrate innovations which improve supported self-management, patient-centred care and access to services. They include:

- Integrating self-management support into rehabilitation post stroke, led by Kingston & St George's Universities.
- Implementing learning from introduction and interpretation of the National Guidance on Rehabilitation Prescriptions, London Trauma Systems.
- Pilot of a neuro-navigator role to support patients who have sustained a traumatic brain injury in North West London, led by Imperial Partnership Ltd.
- Pilot of a web passed rehabilitation referral system in North West London led by Imperial College Health partners.
- Development of a service for patients who sustain complex musculoskeletal injuries as a result of major trauma.

It is unclear whether these snapshots are truly representative of the key areas in London where innovation is happening or simply emblematic of the areas where there is time and capacity to complete the paperwork. It is clear that within London, innovations are happening within services which operate within Strategic Clinical Networks and areas where there is strong clinical and strategic leadership and a focus towards innovation and service. Of course this is not to say that there is not a passion for improvement in areas that do not operate within networks, just that it may not be as easily facilitated. It appears that network working and clinical leadership are key enablers for innovation and therefore vital to continue to develop within the rehabilitation community in London.

5. Engage with LETB's in the region and:

   a. Identify lead for workforce planning for rehabilitation

   b. Raise profile of need to consider workforce planning to support new models of service delivery

And

6. Engage with regional SCNs, AHSNs and clinical senates and create a list of contacts for each

The process used to make contacts with these key stakeholders in London was via the Wider Area Team Medical Directors and their mailing lists. A full list of contacts are available outwith this report.

Following attendance at a Medical Directors meeting, the RRL was asked to write a brief synopsis of her role and key objectives which was then sent to key stakeholders by each Medical Director. Contacts were followed up via email and where appropriate, telephone calls and/or visits were made.

The RRL in London has had some engagement with all three LETBs but this work needs to be developed and strengthened as the National Rehabilitation Programme work develops. A recent publication by the Council of Deans for Health[14] has highlighted that *'staff shortages are putting health and social care services under pressure, with England currently facing one of its most profound and sustained workforce crises in decades'.* The document also acknowledges the needs for transformational change and better integration of services which will largely depend *,"not on new structures but on the people who work in health and social care, who will need to adapt to new roles and services and learn new skills…"*[14]

Clearly when viewed alongside other key documents like the Five Year Forward View and the London Health Commission report, this highlights an important need for workforce development.

There is representation from the LETBs at the AHP Advisory Group meetings and the RRL has had some engagement via this forum and ensured representatives are cognisant of her role and how they might work together. The RRL in London has also attended several events which have involved the LETBs and have been important influencing opportunities. Two of these are described below.

- The Health Education North West London SHARP Project (Sustaining Healthcare: AHPS – Realising the Potential) held a workshop on 12/11/14 to share the findings from a collaborative project involving Allied Health Solutions, HENWL and Bucks New University. This project described the impact of AHPs across some 3 key service areas in North West London (Dementia care, Rehabilitation & Re-ablement and Transfer of care across integrated services) and explored the future potential that AHPs could have. It was an important networking event and an opportunity to help shape the future direction of the project as well as be guided by key findings so far. An article on the preliminary work will be available within the next few months.
- The RRL in London attended the Clinical Senate meeting on 22/1/15 entitled "Transforming the Healthcare Workforce" where the LETBs had a strong presence. It was an important event in shaping the future direction for workforce development and to influence the LETBs around how they are engaging with the AHP workforce. The RRL, working with the NHS England Regional AHP Lead for London ensured a good AHP presence at the event to ensure the needs of the AHP workforce were well represented. Some important messages were delivered about the loss of specialist AHP posts despite a 12% growth in qualified AHPs over the last 5 years and the need to develop leadership in AHPs and a clear career pathway to Consultant level. Table discussions highlighted how the workforce will need to develop to meet the changing health and social care needs of our communities and it was evident that AHPs already possess many of the skills that are needed to improve outcomes for patients. The focus that AHPs have on individualised, patient-centred care, supported

self-management and on return to optimal quality of life and function was discussed and highlighted as a key strength and vital to capitalise on.
- The Transforming Primary Care for London – Together event on 26/11/14 was an opportunity for the RRL to meet with representatives from all three LETBs and discuss workforce development in line with changes to Primary Care. It was a key influencing opportunity to ensure that when LETBs talk about workforce development in primary care they think beyond traditional roles, such as General Practitioners (GPs) and Practice Nurses. There is an opportunity to make stronger links with LETBs related to this work.

Moving forward, it is clear that partnership working with the LETBs will be vital to develop a workforce which is fit for the future and to ensure that high quality rehabilitation is part of every patient pathway.

The RRL has had good initial engagement with the SCNs and AHSNs but more work is needed. Some examples of the work that has been undertaken are shown below:
- The RRL has attended several meetings organised by the Stroke Clinical Leadership Group (part of the Cardiovascular Disease SCN) and has assisted them in developing their work on Vocational Rehabilitation (VR), see also page 15. It is clear that many services are finding the commissioning of VR a real challenge and this appear to be because there is currently no perceived financial incentive for the NHS to invest in VR as the financial benefits appear to fall outwith the NHS and to other agencies. This is paradoxical as return to occupation is currently a priority area for NHS England. The project manager of the SCN has found this partnership working helpful and stated,

"The majority of the London Stroke Strategic Clinical Network's work plan focused on rehabilitation of stroke survivors, and thus directly benefits from the resource Karen provides as Rehab Lead. She has worked in partnership with the Network on a variety of work streams, including most recently by inputting into two documents created by the vocational rehabilitation work stream. This work is not completed however, and the group sees value in the continuation of the London Rehab Lead role, and working with Karen in particular" (Jess Brand, Project Manager CVD Strategic Clinical Network).

- The RRL attended an initial meeting with staff at UCLP to better understand the Integrated Cardiovascular system and the work they are doing in rehabilitation. A further meeting took place between the Programme Manager for the Integrated Cardiovascular system, the Programme Lead for the Frailty Programme at UCLP and a Programme Manager from the SCN (all AHPS). The aim of the meeting was to share ideas around the 'specialist vs generalist' debate in light of some changes to the commissioning of neurological rehabilitation in London. Staff at UCLP has found the regional lead role valuable with one staff member stating,

"Having a regional AHP lead across the various micro and macro systems of patient pathways has enabled discussions and co-ordinated networking across a complex health and social landscape. This has resulted in sharing

approaches and learning across the AHP network, in regards to capitalising on previous knowledge to drive forward improvement in services which aim to meet patient needs, particularly from a rehabilitation point of view" (Mirek Skrypak, Prevention Programme Manager, Integrated Cardiovascular System, UCLP).

- The RRL has engaged with Imperial College Health Partners to promote and disseminate the work of the Neuro Rehabilitation Project. This project is led by Jess Henderson and is designed to improve access to neuro-rehabilitation services for patients and has 3 strands; demand and capacity modelling, a web-based tool for referrals and neuro navigator posts. The web based tool will generate important data around unmet needs which will help guide future commissioning intentions. Referrals should go 'live' in early July 2015 and the project will be evaluated using a range of metrics including user satisfaction and cost-savings. There is significant potential for this project to be replicated across London and a key milestone is October 2015, when preliminary results will be presented at the CCG Collaborative Board.
- The RRL has attended two Clinical Senate meetings and has met with the Clinical Senate Programme Lead to discuss issues relevant to rehabilitation. There is a need to get consistent engagement from AHPs at all future Senate Forum Meetings and it is also important to consider how we can ensure that rehabilitation is adequately championed at Senate Council level. There is potential to involve the Senate Council in any future work in developing quality standards for rehabilitation in London.

7. Make contact with CCGs in the region and where possible identify contact for commissioning of rehabilitation services

The process used to make contacts with CCGs in London was via the Wider Area Team Medical Directors and their mailing lists. The lists of contacts made are held outwith this report but available by NHS England if needed. Contact with CCGs was also made via the AHP Advisory Group and at other fora where commissioners were present e.g. London Clinical Senate meetings and the 'Transforming Primary Care – Together' event. Very few CCGs made an approach following receipt of the email but, where contact was made, it was for a very specific purpose related to a specific project or task. The following examples provide further detail on some of the engagement with CCGs and the potential for future work.

- There is significant potential for further collaboration with the Transforming Cancer Services Team (TCST) in London, a pan-London Commissioning Support Unit (CSU). Meetings with the Lead for Living With and Beyond Cancer (LWABC) have identified some key areas where NHS England and the CSU could work together to improve outcomes for patients. Cancer is increasingly being seen as a Long-Term Condition (LTC) and the Commissioning intentions for London currently include implementation of the 'Recovery Package' (which is included in the 5YFV) as well as management of some key consequences of treatment where rehabilitation plays a key role; namely sexual dysfunction, pelvic radiation disease and lymphoedema. The TCST has previously worked with the Mental Health SCN to improve

psychological support services for cancer patients and the model used is worthy of replication. Previous work used a combination of stakeholder events and service mapping which led to clear recommendations for commissioning of psychological services. Lymphoedema is one area which could, and should, be prioritised as the economic argument for better care is strong. Improved lymphoedema services in England could reduce the need for hospital admission and IV antibiotics. For every £1 spent on lymphoedema services, the NHS saves £100 in reduced hospital admissions[15]. Clearly, partnership working is going to be key in improving outcomes for patients as shown below,

"The pan-London five year cancer commissioning strategy[16] outlines a number of priorities areas some of which relate specifically to the consequences of anti-cancer treatment; namely lymphodema, pelvic radiation disease, sexual dysfunction, psychological support, pain and fatigue management. In order for the Transforming Cancer Services for London team (TCST) to deliver on this strategy with London CCGs and other partners, it is imperative that we have the support and expertise of the NHS England (London) Rehabilitation Programme. They are a primary partner in delivering the priorities for the 180,000 Londoners who are living with and beyond cancer. As such the TCST would like to undertake a number of joint projects with the London rehab programme during 2015/16." (Liz Price, LWABC Lead, TCST).

- Several CCGs have made contact for support for specific projects e.g. redesign of a musculoskeletal physiotherapy pathway and refinement of business cases for additional rehabilitation staff and resource. There is great potential to develop this work and to ensure that CCGs have better access to support with commissioning decisions when no “in-house’ expertise is available.
- There is significant potential to better inform CCGs where investments in rehabilitation can lead to cost-savings and a good example of this is the economic modelling tool which has been developed by the Chartered Society of Physiotherapy (CSP) to show the value of physiotherapy interventions for Falls[17]. It is clear that this tool is worthy of wider roll-out but the best forum with which to engage CCGs about this type of work is still unclear and needs attention.

Overall, despite some promising engagement there is a significant need to strengthen engagement with CCGs in London around all aspects of rehabilitation. Rehabilitation is often hidden within block tariffs and feedback from many stakeholders has indicated that CCGs are struggling with the commissioning of rehabilitation for many reasons including knowledge of what rehabilitation is; the scale of the problem due to insufficient data; what needs to be commissioned and for what population; what good looks like and how best to deliver it. It is clear that the majority of CCGs have no dedicated commissioning support for rehabilitation and this is an area that needs attention in London.

The landscape in which commissioning operates is clearly changing and it is clear that citizen’s outcomes are now at the heart of commissioning decisions.

By focusing on outcomes, there are huge opportunities for commissioners to think beyond traditional clinical boundaries and to work more collaboratively with partners in local communities. There is also a need to move away from a traditional 'biomedical model' where people are seen as patients and passive recipients of care to a more biopsychosocial model where people are enabled to be active participants in their care. This biopsychosocial model is wholly aligned with how rehabilitation should be delivered and there is significant potential for the RRL to work with CCGs to help them better understand what good looks like and how to measure quality, to ensure continued improvements in rehabilitation across all care pathways.

8. Identify current service data collection and service evaluation (including audit, research and economic evaluation) and support local implementation of pilots where appropriate.

The benchmarking work described earlier and a range of clinical visits have identified that most services are collecting data related to patient outcomes and service delivery but many feel this is an area that needs development. A wide range of quality indicators are collected by services and a summary of those identified by the benchmarking work are included in Table 2. Some services e.g. the neurological rehabilitation unit and the HIV/AIDS rehabilitation team collect a wide range of data including audit, Key Performance Indicators (KPIs) and a wide range of outcome measures whilst others, e.g. the orthoptic stroke service and the surgical Occupational Therapy (OT) team, collect only basic data. Very few services are collecting data that measures the economic or social impact of rehabilitation. For example, measuring the impact of rehabilitation on an individual's ability to return to occupation is hugely important but is not routinely captured. The NCD for Rehabilitation and Recovering in the Community has recently made a strong economic argument for rehabilitation services outlining how rehabilitation can improve clinical and economic outcomes and *'must become a key activity in the new NHS'.*

There is a significant appetite in London to undertake focused work to improve the evaluation of rehabilitation services with one well respected Professor of Rehabilitation suggesting that we need to, *"wipe the slate clean and start again".* A recent Healthwatch Foundation/Nuffield Trust publication[18] investigated the quality of care and services delivered by AHPs and one of the key observations was, *"the importance of developing information systems that would collect consistent and comparable data on all aspects of the quality of care delivered by AHPs".*

Other stakeholders have commented on the issues with data collection on rehabilitation and have stated, *"I think it's gone backwards, there is no consistency…"* and, *" ...informatics and data have been neglected".*

There are some services in London who are doing excellent work in data collection and this has been found particularly where integration of health and social care has been undertaken, services operate within networks, strong links with academic teams are in place or the team members have good R&D skills. It is clear that wider dissemination of good practice will be useful in facilitating better data collection but that it only part of the answer.

It is clear that a strategic decision needs to be made about how best to develop better data systems and the ‘big data’ on rehabilitation which is needed to drive improvement in outcomes for patients.

One example of the benefit of collecting consistent data sets to inform commissioning is the UK specialist Rehabilitation Outcomes Collaborative (UKROC). This was set up through a Department of Health NIHR Programme Grant in September 2008 and is led by Professor Lynne Turner-Stokes. UKROC aims to develop a national database for collating case episodes for inpatient rehabilitation. In the first 5 years it has focused on neuro-rehabilitation and ultimately included data from all specialist Level 1 and 2 neuro-rehabilitation services, across the UK. It is a Payment by Results (PbR) Improvement Project which provides information on case mix and episode costs to inform the development of complexity-weighted tariffs. But more importantly it has provided information on rehabilitation requirements, the inputs provided to meet them, outcomes and cost-benefits of rehabilitation for patients with different levels of neuro-rehabilitation need. More information can be found at: http://www.ukroc.org[19].

Team	Quality indicators collected	Outcome measures used (if stated)
Community Neuro team	Audit against Stroke Guidelines; satisfaction questionnaire; KPIs; outcome measures	not stated
Acute neurological step-down team	Service user satisfaction; outcome measures	not stated
In-patient acute neurological rehab team	Friends and Family Test (FFT); 'how are we doing' survey; outcome measures	FIM/FAM (functional independence measure/functional assessment measure); Rivermead mobility index
Neurological rehabilitation unit	Outcome measures; audit; service user satisfaction; staff satisfaction	FIM/FAM; goal attainment scale; rehabilitation complexity scale; neurological impairment set; Northwick park nursing dependency score Discipline specific measures as needed: Berg balance test; 10m walk test; action research arm test
Stroke Unit and HASU rehab team	FFT; audit, 'how are we doing' survey; outcome measures; KPIs – London Stroke strategy performance standards	FIM/FAM; modified Rankin scale; Orpington prognostic scale
Acute neurosciences rehab service	Audit; patient satisfaction survey; KPIs; length of stay; time to referral to appropriate services	not stated
Surgical Occupational Therapy team	Patient satisfaction survey; KPIs	not stated
Orthoptic stroke service	Audit of patient referrals and outcome after first appointment	not stated
Orthopaedic occupational therapy team	Patient satisfaction questionnaire; KPIs	not stated
Major trauma therapy team	Patient Reported Outcome Measures (PROMS); patient satisfaction survey; Trauma Audit & Research Network (TARN) data fields; service gap analysis on needs met at point of discharge	Rehabilitation complexity score; Glasgow outcome score
Elderly rehabilitation unit	Audit; outcome measures; service user satisfaction; KPIs	not stated
Adult musculoskeletal service	Outcome measures (specialist & general); audit of outcomes, patient satisfaction and onward referrals; KPIs	EQ-5D-5L (EuroQol Quality of Life questionnaire)
Mental health rehabilitation team	Audit; clinician rated outcome measures; KPIs; PROMs; patient rated experience measures	not stated
Specialist cancer rehabilitation team	Audit; patient satisfaction; PROMS; KPIs; waiting times	not stated

Oncology therapies team	Audit; PROMS, benchmarking against NICE guidance	Shoulder Pain and Disability Index
Cancer survivorship programme	Satisfaction questionnaires; PROMs (physical activity, diet coping with cancer, mental well-being); attendance figures	not stated
* HIV/AIDS Rehabilitation	Audit; service user satisfaction; outcome measures; adherence rates	Goal attainment scale; 6 minute walk test; 1 rep max; sit and reach test, functional assessment of HIV measure
Renal rehabilitation team	Audit; satisfaction questionnaires; service user outcomes; PROMS; KPIs	6 min walk test; sit to stand in 60 secs; Duke activity status index
Pain management programme	Friends & family test (FFT) British Pain Society mandated indicators including physical measures and PROMS	not stated
* Osteoarthritic pain self-management course	Service user satisfaction; service user outcomes; outcome measures; KPIs	Hospital anxiety and depression scale; self-efficacy for exercise, patient satisfaction questionnaire; KOOS knee survey
Long-term conditions podiatry team	Audit against NICE Guidelines and care plans; patient satisfaction; FFT; KPIs; compliment slips; outcome measures	EQ-5D

***Table 2**: A description of data collected by teams in the benchmarking work using the template*

5 Key Findings

5.1 The key findings from this work can be summarised as follows:

1) **There is poor awareness of the scope of rehabilitation and the fact that rehabilitation happens along and across every pathway of care.** Many people have a simplistic 'medical model' interpretation of rehabilitation and do not understand the complexity. Rehabilitation is often attributed to the end of the treatment pathway e.g. after an operation, and not attributed to prevention or much earlier in the pathway e.g. prehabilitation. Rehabilitation is better understood in certain areas e.g. neurological rehabilitation or musculoskeletal but less well understood in other areas such as managing the consequences of cancer treatment or in public health. Rehabilitation is often associated with the specialist workforce and with AHPs, with little awareness that the wider workforce have a hugely important role in helping people regain their full functional potential. It is clear that we need to continue to raise the profile of all rehabilitation services (including those that are not badged or named as rehabilitation) in the region with commissioners, providers, area and regional teams and clinicians. We need to promote the programme's vision for rehabilitation services by embedding the need for rehabilitation to be an integral part of every episode of care. We must continue to ensure that "Rehabilitation is everyone's business" and that rehabilitation is framed in the context of key drivers such as the Five year forward view[2] and the London Health Commission report[3].

2) **There is little to guide commissioners, providers, area and regional teams and clinicians on what good looks like and how to measure it.** The RRLs have disseminated the 'Principles and Expectations for Good Adult Rehabilitation' but this work remains unpublished (NB The current plan is to have this paper published by Wessex Strategic Clinical Network – see below). There is no formal national or regional governance framework for rehabilitation to guide commissioning decisions and help service providers (and others) to improve outcomes for patients. Vocational rehabilitation is one area where providers are struggling to get services commissioned despite good economic evidence and return to work being a priority for NHS England. The recently published Wessex Strategic Clinical networks' 'Rehabilitation, Re-ablement and Recovery Quality Guidance document' [9] will be a useful reference document for any future work.

3) **There appears to be consensus amongst stakeholders on the lack of quality data relating to many aspects of rehabilitation service delivery**. This has been backed up by recent reports and offers a significant opportunity for improvement. There is uncertainty over the scale of need for rehabilitation and the current demand in London. There is a need for consistent datasets that measure citizen outcomes at a local level and can influence commissioning decisions and drive change. Few services are measuring the economic and social impact of their rehabilitation interventions and good practice seems to exist where integration of health and social care has been undertaken, teams operate within networks, strong links with academic teams are in place or the team members have good R&D skills. There is great variation in the use of patient and service-

reported outcome measures and patient outcomes should be given parity of esteem with other outcomes.

4) **Developing the workforce and building teams that are fit for the future is key to the delivery of better outcomes for citizens.** This is clearly a priority in London as the recent Clinical Senate meeting (Jan 2015) was dedicated to this topic. There are many challenges in the system with many staff feeling demotivated and experiencing "change-fatigue". There are no clear guidelines on safe staffing levels in the rehabilitation workforce and across many areas of London there are significant issues with recruitment and retention. There is a clear need for a culture change towards a health and social care system that empowers and enables citizens and has a stronger focus on Prevention and Healthy Lifestyles. Developing skills in areas such as Motivational Interviewing and Health coaching is going to be vital as is developing clinical skills in clinical areas that are going to see an increase in demand for rehabilitation such as "Living with and beyond cancer". There is a need to train the workforce in developing a 'rehabilitative mind-set' to better enable them to work in an empowering and rehabilitative way. There is a significant consensus on the need to develop leadership in the rehabilitation workforce, particularly AHPs, and this was also highlighted at the January Clinical Senate meeting. Literature suggests that, "AHPs *are rarely the subject of major policy debates and there is concern that their contribution to care is often hidden, overlooked or potentially undervalued*"[17].
Moving forward it is important to ensure that there is sufficient regional leadership to ensure that the rehabilitation workforce are adequately represented and considered when key policy decisions are made in London.

5) **Networks seem to be an important enabler for the sharing and dissemination of good practice in London** and have played a significant role in adoption of good practice and delivering transformation change in rehabilitation. It is vital to learn lessons from, and support, existing networks but also to set up new ones which can continue to deliver service improvements pan-London. The Improving Rehabilitation Services Community of Practice has outlined some key points about what the community needs to do (see page 17) and this learning should now be used and implemented in London.

6) **There appears to be a real need for a regional lead presence in London to drive transformational change in rehabilitation**. The RRL post in London has brought a high-level oversight and 'helicopter view' of the system that has been valued by stakeholders. This oversight is required to ensure sharing and dissemination of good practice, better understanding of the scope and breadth of rehabilitation, guidance to commissioners and others on what good likes like and generally to be a 'champion' for rehabilitation services in London. There is a risk that the absence of a RRL could leave a vacuum in the system and momentum for change could be lost.

7) **There are myriad opportunities for transformational change in rehabilitation services offered by the current health and social care landscape**. Both the Five Year Forward View[2] and the London Health Commission report[3] are timely for achieving the vision of the Improving

Rehabilitation Services Programme. There are significant opportunities to make linkages between rehabilitation and the priorities arising from these publications with some of the key areas being population wellbeing; prevention; living with and beyond cancer; managing frailty; staff wellbeing; reducing inequalities for children and young adults etc. The recent announcement of 2 vanguard sites in London for the New Models of Care Programme (Tower Hamlets & Sutton) as well as the Transforming London's Community Services Programme and the Primary Care Transformation in London (amongst others) mean there is significant potential to develop new and innovative service models in rehabilitation, test these models comprehensively and ensure wider roll-out.

6 Themes & Recommendations

6.1 Themes

The main findings to emerge from this work can now be grouped into 6 main themes to guide future work and these are:

1. Raising awareness of rehabilitation
2. Defining what good likes like
3. Improving data
4. Workforce development and planning
5. Developing networks
6. Regional leadership

6.2 Key recommendations

Raising awareness of rehabilitation:

- The London AHP Advisory Group should develop a strategy to consider how best to raise the awareness of rehabilitation and the rehabilitation workforce in London.

Defining what good likes like:

- NHS England should develop a National Framework for Rehabilitation and a Driver Diagram for the National Improving Rehabilitation Services Programme.
- NHS England London region should establish a working group to develop 'pan-London Quality Standards for Rehabilitation' and a 'Governance Framework' to guide commissioning decisions and service development work.

Improving data:

- Commissioners need to better understand the scale of need and the current demand for rehabilitation in London.
- The system needs consistent datasets that measure citizen outcomes at a local level and can influence commissioning decisions and drive change

- NHS England should develop guidance for service providers on measuring the social and economic impact of their rehabilitation interventions.

Workforce development and planning:

- The London AHP Advisory Group should lead on establishing a 'task and finish' group to pilot the impact of additional training in supported self-management (e.g. health coaching/motivational interviewing) for the rehabilitation workforce.
- The London AHP Advisory Group should continue to influence around the need to develop leadership in the rehabilitation workforce (and particularly AHPs) in London.

Developing networks:

- NHS England London region should work with partner organisations to establish a new pan-London 'Service Improvement forum for Rehabilitation' to better network the rehabilitation workforce around delivering transformational change. This should build on the work already started by the RRL and the learning from the Improving Rehabilitation Services Community of Practice.

Regional leadership:

- NHS England London region requires regional leadership for rehabilitation to take advantage of the myriad opportunities in the current landscape to ensure the vision of the National Rehabilitation Programme is delivered in London.

In addition to the key recommendations there are specific pieces of work which have been started by the RRL and should be prioritised for continued attention and support. These are:

- Further collaboration with the Transforming Cancer Services Team (TCST) in London to improve the management of consequences of cancer treatment in line with the London Commissioning Intentions for Cancer. Priority should be given to developing clear recommendations for the commissioning of Lymphoedema services.
- Continued work with NHS Enfield CCG, Royal Free London NHS Foundation trust and Barnet, Enfield & Haringey NHS Mental Health Trust to model the pathway for developing new integrated rehabilitation services.
- Continued work with the Cardiovascular SCN to a) support the development of their work on Vocational rehabilitation and b) support the commissioning of neurological rehabilitation services in light of the current debate around specialist vs generalist rehabilitation
- In the absence of a new Service Improvement Forum for Rehabilitation (see above) continued work is needed with the services that completed a template for the benchmarking work and the services who submitted a snapshot of innovation, to ensure continued service development and dissemination of good practice.

7 National Rehabilitation Programme Work Streams

The work of the four Regional Rehabilitation Leads in NHS England has highlighted some common themes that will need to be addressed at a national level in order to support regional improvement in rehabilitation services. The national team is committed to focussing on these areas:

National Rehabilitation Commissioning Framework

A national rehabilitation commissioning framework will be developed in response to both the recommendations from the regional rehabilitation Leads and requests from commissioners for support and guidance in commissioning rehabilitation services. The aim of the commissioning framework is to raise the profile of the benefits of good rehabilitation services and provide the evidence that will enable commissioners to realise the potential of rehabilitation services in addressing the priorities for their local populations. Work has begun to develop initial guidance for commissioners including a compelling narrative for rehabilitation services and benchmarking tools based on the Principles and Expectations for Good Adult Rehabilitation (available at https://www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/principles-expectations).This work builds on the development of the tool developed by the Regional Rehabilitation Leads and described in this report.

The Rehabilitation Workforce

The Rehabilitation Programme board has established a working group with a remit to ensure the future rehabilitation workforce is fit for purpose. This group has multi-disciplinary representation and will liaise closely with Health Education England (HEE) via its chair Suzanne Rastrick, Chief Allied Health Professions Officer whose remit crosses both NHS England and HEE and who also chairs the Allied Health Professions HEE Advisory Group.

Demonstrating Effectiveness

It is vital that rehabilitation services can demonstrate their effectiveness in improving outcomes for people, their families and carers and providing evidence of the economic benefits of services. The lack of consistent data across AHP and rehabilitation services is highlighted in all regional reports. Work will commence this year in NHS England under the leadership of the Chief Allied Health Professions Officer and in collaboration with HSCIC and the National AHP Informatics Strategic Taskforce to develop AHP datasets. The Rehabilitation Team will work closely with colleagues in NHS England to contribute to ongoing work to develop a complete community services dataset. AHP Referral to Treatment data collection has been mandated since 2014 within the community information dataset and will be incorporated into other data sets as they are renewed. This information can be used as a tool to measure improvements in accessibility as part of service improvement and redesign.

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9 Appendices

9.1 The template used for benchmarking services against the Principles for Good Adult Rehabilitation.

It is time to transform rehabilitation services in the NHS – your input is needed.
Improving Rehabilitation Services Programme (IRS)

There are excellent examples of adult rehabilitation services throughout England; however, clinicians and service users tell us that in many areas their needs are not being met. This must change. The NHS is unlikely to be successful in meeting its mandate unless it has effective and efficient rehabilitation services - for everyone.

The Improving Rehabilitation Services (IRS) Programme was set up following a 'case of need' for better adult rehabilitation services as presented by the Chief Allied Health Professions Officer in 2012. During 2012 and 2013, the IRS programme leads conducted extensive discussions with a variety of stakeholders including patients, healthcare professionals, commissioners, Strategic Clinical Networks and NHS England National Clinical Directors. There was a strong consensus that the system needs to change and that rehabilitation must be underpinned by robust principles.

The set of principles and expectations which has been developed describe what good practice looks like and are deliberately ambitious and challenging. They relate to the full spectrum of adult rehabilitation services which the NHS delivers and include all people whom the NHS cares for. The principles outline the key features of a good rehabilitation programme from the perspective of service-providers, commissioners and others. The expectations describe what service-users expect and deserve from the NHS and are written as "I" statements. They are drawn directly from the comments of service-users at the stakeholder meetings and from previous patient engagement exercises.

A key element of the ongoing IRS work is to 'pilot' these principles and expectations for good adult rehabilitation services and your input is needed. We are focusing firstly on the principles and have developed a template which will enable you to self-assess your service against these principles and identify potential opportunities for service development and improvement. The template for completion is shown on pages 2-5. Please be aware that any evidence we gather will be anonymised and will be used for Regional and/or National reporting.

Core Service Model Information

Focus	Question	Example answer
What is the service?	Team name/title	
	Describe your service	Free text - short description of service e.g. District service team providing care to 2000 people
	Do you have a service specification?	Yes/No
	Define the services provided in the following categories	Patient-facing, patient related non-patient facing, additional operational activities (meetings/admin/training) in-reach/outreach, other
Where and When and who provides the service?	Where is the site for provision of the service?	e.g. clinic, school, service-user's home, geographical location
	How often is this service provided?	1 day a week, 2 days a week, 3 days a week, 4 days a week, 5 days a week, 6 days a week, 7 days a week, ad-hoc, monthly, bi-monthly, fortnightly
	When is this service provided?	Normal day, extended day, evenings, night, 24 hours, on-call
	Which staff group provides support in the delivery of this service?	How many staff / grades / skill mix
How many people does the service serve?	What is the average annual number of ongoing cases?	Number
	How is this captured?	PAS, local electronic, local paper based, unknown
	Who is the referrer?	Who is the referrer, on what basis are they referred?
	What are the pathway expectations	Average number of contacts, average length of stay, etc.
	What are the discharge criteria for your service?	
Quality Information/demonstration of effectiveness	What quality indicators are collected?	Audit, service user satisfaction, service user outcomes, outcome measures, KPIs, PPIs
	What quality indicators would you like to collect?	Free text

The Principles of Good Practice in Adult Rehabilitation Services

N.B. The examples of evidence shown below are not a definitive list and additional evidence can be provided.

Key messages based on the principles of good practice are that services:	Examples of evidence of good practice	Service specific development opportunities identified	Barriers to service development/meeting the principles
1.Optimise physical, mental and social wellbeing ,and maximise outcome, independence and quality of life	E.g. standardised outcome measures, clinical protocols, MDT working, family/carer engagement.		
2. Promote partnership working with all stakeholders, including patients, carers and relatives	E.g. patient/user identified goal setting, MDT working, family and carer engagement.		
3. Use an individualised, person centred goal setting approach,	E.g. function focused goals, evaluation against goals set, goal setting takes in to account persons needs and wants.		
4. Deliver early and ongoing assessment; identify rehabilitation needs; provide appropriate therapeutic interventions to enable improved outcomes and seamless transitions,	e.g. Assessment tools, National frameworks, service evaluations, patient experience, validated outcome measures		
5. Support self-management through education and information.	E.g. access to health and well-being information e.g. verbal, written, online		

	etc., self-management strategies used evidence of evaluation outcomes.		
6. Utilise a range of interventions underpinned by best available evidence.	e.g. Evidence based practice, evidence of continuing professional development within the service .NICE guidance ,skill mix		
7. Deliver a cost effective and efficient rehabilitation service using integrated, multi agency pathways and 7 day services where appropriate.	e.g. Cost savings and benefits, cross boundary working ,links with other agencies, evaluation of 7 day service		
8. Have strong leadership and accountability at all levels - with effective communication.	E.g. lines of accountability are clear and documented, vision and values are clear and demonstrated in culture, clear roles and responsibilities are identified for team members.		
9. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research.	e.g. examples of service development and quality improvement initiatives, evidence of reporting processes, research strategy and examples of publications/presentations etc., sharing of good practice outwith own team, service, organisation.		

This is a pilot tool. Please provide any comments about the principles, the template, ease of use or any other issues in the open space below.

Contact details;

Name ____

Organisation ____

Telephone ____

Email ____

Please forward this to one of the four Regional Rehabilitation Leads to provide the foundation for evidencing effectiveness and good practice, and contribute to developing improved rehabilitation services.

Lead	Region	Email
Karen Robb	London	karen.robb3@nhs.net
Jackie Turnpenney	South	jackieturnpenney@nhs.net
Sarah Sewell	North	sarah.sewell1@nhs.net
Joanne Fillingham	Midlands and East	jo.fillingham@nhs.net

Are you delivering innovation right now? We would really like to capture this using our 'Snapshot' template' (please ask one of the leads for the template). This template would also support services that may have identified development opportunities above.

9.2 Principles and Expectations for Good Adult Rehabilitation

9.2.1 The Expectations of Good Rehabilitation Services:

- I have knowledge of, and access to, joined up rehabilitation services that are reliable, personalised and consistent.
- My rehabilitation will focus on all my needs and will support me to return to my roles and responsibilities, where possible - including work.
- My rehabilitation experience and outcomes are improved by being considered by everyone involved with my health and wellbeing working in partnership with me.
- My rehabilitation supports me and gives me confidence to self-care and self-manage, making best use of developing technologies and stops me being admitted to hospital unnecessarily.
- The goals of my rehabilitation are clear, meaningful and measured and there is recognition that my goals may change throughout my life.
- My rehabilitation supports me in my aspirations and goals to reach my potential.
- I can refer myself to services easily when I need to and as my needs change.
- There is a single point of contact available to me where there is the knowledge and skills to help me.
- People who are important to me are recognised and supported during my rehabilitation.
- I am provided with information on my progress as I need it and information is shared, with my consent, with those who I agree are involved in my rehabilitation.

The Principles of Good Rehabilitation Services:

- Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs.
- Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team.
- Instil hope, support ambition and balance risk to maximise outcome and independence.

- Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society.

- Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition.

- Support self-management through education and information to maintain health and wellbeing to achieve maximum potential.

- Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy.

- Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week.

- Have strong leadership and accountability at all levels - with effective communication.

- Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research.

10 Glossary

AHSN	Academic Health Science Network
CAHPO	Chief Allied Health Professions Officer
CCG	Clinical Commissioning Group
CLG	Clinical Leadership Group
CPD	Continuing Professional Development
CSP	Chartered Society of Physiotherapy
CSU	Commissioning Support Unit
CSIS	Clinical Soft Intelligence Service
CYP	Children and Young People
EQ-5D-5L	EuroQoL Quality of Life questionnaire
FIM/FAM	Functional Independence Measure/Functional Assessment Measure
FFT	Friends and Family Test
GP	General Practitioner
HEI	Higher Education Institution
HENW	Health Education North West London
HIUN	Health Innovation Network
IRS	Improving Rehabilitation services
IRS COP	Improving Rehabilitation services Community of Practice
KPIs	Key Performance Indicators
LETB	Local Education and Training Boards
LCA	London Cancer Alliance
LTC	Long-Term Condition
LWABC	Living With and Beyond Cancer
MI	Motivational Interviewing
NHSIQ	NHS Improving Quality
OT	Occupational Therapist
P&Es	Principles and Expectations for Good Adult Rehabilitation
PT	Physiotherapist
PROMS	Patient Reported Outcome Measures
R&D	Research & Development
RRL	Regional Rehabilitation Lead
SALT	Speech and Language Therapy
SCN	Strategic Clinical Network
TCST	Transforming Cancer Services Team
UCH	University College Hospital
UCLP	University College London Partners
UKROC	United Kingdom specialist Rehabilitation Outcomes Collaborative
VR	Vocational Rehabilitation