

# RightCare: Community Rehabilitation Toolkit

*Community rehabilitation services can be uncoordinated and inconsistent, with supporting data to help improve services lacking and the workforce is often insufficient to meet current need.*

*If you face some of the above issues in your area, you can use this toolkit as a key resource in helping community rehabilitation services.*

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## RightCare Community Rehabilitation Toolkit

This NHS RightCare system toolkit will support systems to understand the priorities in community rehabilitation care and the key actions to take. It provides opportunity to assess and benchmark current systems to find opportunities for improvement. It is produced with reference to an expert group of stakeholders and is supported by NICE. Wider consultation has taken place with patient representatives, clinicians, social care organisations, professional bodies and other key stakeholders ([see acknowledgements page](#)).

### The National Challenges:

- Inequalities in care and **unwarranted variation** in commissioning of services
- Community rehabilitation services are commissioned for single conditions, rather than on a needs basis, which leads to fragmented systems and services with uncoordinated working.
- Insufficient workforce and inadequate skill mix across settings which can be less responsive to patient needs to prevent admissions to secondary care
- Lack of data on both quality and quantity of community rehabilitation services commissioned, with little robust data available on long-term patient outcomes

### Scope of this pathway

Rehabilitation cuts across the health and social care system supporting people who are in different settings and who have individual needs. This RightCare toolkit aims to support the commissioning of holistic community rehabilitation services that are based around people's needs rather than being condition specific. This toolkit aligns with the [Ageing Well Programme](#) established to implement the [Long Term Plan](#) commitments of delivering access to community crisis response services within 2 hours and reablement care within 2 days where clinically appropriate by 2023/24. However the scope of the toolkit is broader than these commitments and therefore local systems should also look for opportunities to commission generic rehabilitation services, where appropriate, delivered by appropriately trained and skilled staff. Services should not only focus on rehabilitation and reablement but also have strong focus on secondary prevention.

### Links to other relevant RightCare Products:

[Frailty toolkit](#)

[Stroke Toolkit](#)

[Falls & Fragility Fractures Toolkit](#)

[Progressive Neurology Toolkit](#)

[Equality and Health Inequality Packs](#)



## Foreword: Improving commissioning of Community Rehabilitation supports delivery of the NHS Long Term Plan

The NHS Long Term Plan makes a number of commitments to improve availability of personalised, community-based support and rehabilitation for people to manage long term conditions. It contains specific goals to improve community support that enables people to better manage frailty, cardiovascular, respiratory and cancer.

More broadly the Long Term Plan has a strategic goal of resetting NHS services to reduce levels of admissions and dependency that result from people not accessing support in the community that they need at an early enough stage. Increasing the capability of local systems to be person centred is a theme that runs through the Long Term Plan.

For rehabilitation this means services tailored to meet the needs of people with different combinations of conditions, differing levels of support needs, and whose needs fluctuate and change over time.

The Long Term Plan recognises over the next decade there needs to be a re-prioritisation of funding, so that resources for the community and primary care sector rises at a faster rate than the acute sector.

To ensure that resources result in better quality and consistency of community rehabilitation we need to improve our data infrastructure. This means community rehabilitation services providing consistent data on service delivery and outcomes, and commissioners using consistent measure of population need.

The Community Rehabilitation Rightcare Toolkit is a valuable resource to support service improvement that has the potential to make lasting change in meeting population need and making the NHS sustainable for the long term.

***Karen Middleton, Chief Executive, Chartered Society of Physiotherapy***

# NHS RightCare Community Rehabilitation Toolkit:

## System Improvement Priorities



## System Improvement Priority: Population identification and segmentation based on symptoms, function and need

It is important to know the population requirements for community rehabilitation. The identification of people requiring these services should be based upon the needs of the individual and not by disease group. Understanding the needs and demand from the population for community rehabilitation services, provides the opportunity to plan and anticipate need along the pathway. Strategies for identification of individuals and stratification of the population should be applied. As important, is knowing what to consistently do when an individual is found to have rehabilitation needs in the community.

### Key areas for focus:

#### System wide recognition when community rehabilitation is required

It is important for all in health and social care to recognise when an individual may require community rehabilitation services. Individuals, families and carers also need to be supported to recognise their own signs of deterioration that could benefit from the input of rehabilitation services. It needs to be recognised that peoples needs will fluctuate, which will require different management strategies at different times as people come in and out of services.

#### Embedded approaches to population segmentation and/or stratification based on symptoms, function and need

Organised approaches to segmentation and stratification based on population needs should be embedded within the local system. Different approaches to population segmentation could be undertaken, examples are the use of the frailty index in primary care or identification of multimorbidity, and they should be linked with acuity and dependency tools to determine the complexity of need. A scale of matched interventions to different stratifications of patients will support an organised system. The primary care network (PCN) service specifications will also support the identification and ongoing support to different population groups, however within this there should still be room for personalised care approaches for individuals.

#### Undertake capacity and demand planning

As with any service or system, a fundamental building block of understanding is to know the capacity and demand within that system. Demand considerations should include how many people, what are their needs (i.e. differing stratified populations), where are they, what services do they require and how will they access them (e.g. home or community based)? Use of [benchmarking tools](#) and reporting into the [Community Services Dataset](#) (CSDS v1.5 and any subsequent versions) in line with the [information standard](#), will support planning across a system.

#### System wide education to support recognition of community rehabilitation needs

A tailored local approach to educating the local healthcare population (including social care staff) about community rehabilitation should be taken. This may include recognising community rehabilitation needs, what community rehabilitation is and how it can benefit people. Depending on local need, this education could be directed to different groups across the health and social care system.

# System Improvement Priority: Population identification and segmentation based on symptoms, function and need

## Actions to take:

System wide recognition when community rehabilitation is required

Embedded approaches to population segmentation and/or stratification based on symptoms, function and need

Undertaking capacity and demand planning

System wide education to support recognition of community rehabilitation needs

- As a system define what form of community rehabilitation is available to individuals based on different levels of needs, and what types of interventions this will include at an individual level
- Ensure approaches to recognition of needs (e.g falls risk, electronic frailty index) requiring intervention by community rehabilitation services are embedded and communicated throughout the system.
- Co-produce with individuals, across health and care services and sectors involved in delivering community rehabilitation systems, the pathways that will be available in the local area based on different levels of stratification and need.
- Rehabilitation services are best delivered by a specialist multidisciplinary team which includes all the professionals required to meet local population need
- Undertake a JSNA to understand the local population and who will benefit from community rehabilitation service and at what level. The JSNA should map out all the care services across the local system.
- Use the electronic frailty index (eFI) , in line with the GP contract, to identify all patients aged 65 and over who may be living with moderate or severe frailty, in order to predict who is most at risk of adverse outcomes
- Define the level of interventions that people with differing community rehabilitation needs will receive and how these will be delivered.
- Review current recognised approaches to population segmentation (such as in frailty) and understand if this can be applied to population community rehabilitation approaches
- Consider all settings (such as bed based, community based, home based, care home based) of community rehabilitation when planning capacity and demand
- Take part in and use the findings from benchmarking tools such as the [National Audit of Intermediate Care](#)
- Used recognised tools including [audit data](#) to support capacity and demand planning.
- Local systems need to work towards e-job planning and [e-rostering](#) to maximise the most of the available workforce.
- Report into the [CSDS v1.5](#) (or any subsequent versions) as per the [DCB1069 Information Standard](#) to enhance data robustness and quality so that it can be used for planning purposes.
- Demand analysis should include the needs of a patient and where those needs should be met.
- Use existing resources in the system to undertake education and training for colleagues
- System-wide education should be based on the latest evidence to ensure that people's needs, including communication needs, are highlighted.
- Consider who is the best to target education around recognition and needs to.
- Ensure patients are involved in the education, understanding for instance how to involve individuals in conversations about community rehabilitation referrals

## System Improvement Priority: Supporting people to stay well and maintain independence

A core part of community rehabilitation is supporting people to stay well and maintain independence, to decrease the risk of disease and reduce the burden of long term conditions. It is important that systems have a coordinated approach to supporting people to stay well, by having care navigation and clear directories of what and where services are available. A cross sector and health care approach must be taken to support this in a system. This aligns with the critical need to support prevention as defined by the [NHS Long Term Plan](#).

### Key areas for focus:

#### Clear point of access into the system for first and follow up care

When people require services it needs to be clear how they can access them. Access to services should be based on level of need and at the level of intervention that the person requires. This access point needs to be communicated throughout the system. Where people have already been within services, having a 6 month review would be beneficial to assess whether they need further treatment and to ensure that any services provided are appropriate to their needs.

#### Ensure care coordination/navigator's are available for signposting to ongoing support

People need help to navigate the system to find, for example, local groups and support services to help them to maintain their independence. This should be considered across the health AND care system. Coordination of care may involve care navigators to support this essential aspect to community rehabilitation.

#### Local directory of services available

A live directory for all services, groups, activities that people can access to support them to maintain independence is important. This supports navigation across the system. Technology could be used to support this approach.

#### Modifiable risk factors

These are factors that people can change to improve their maintenance of independence, and stay well. People will frequently need support to understand how to address these risk factors, and what is available in the system to support them to do this. Promotion of interventions should be made in a clear and accessible manner, as many people that will require these services may have cognitive impairments that makes access or understanding information difficult.



## System Improvement Priority: Supporting people to stay well and maintain independence(continued)

### Key areas for focus:

#### **Embedded social prescribing**

[Social prescribing](#) and community-based support is part of the NHS Long-Term Plan's commitment to make personalised care business as usual across the health and care system. Through social prescribing initiatives, people should also be referred to peer support which is a vital part of ongoing community rehabilitation and is helpful for individuals to talk, share their experiences and learn from one another.

#### **Increased access to services when in the community**

People with community rehabilitation needs require timely access to services when they need it to help them maintain their independence. People should have access to professionals they know, so their care continues seamlessly, although it is recognised that this may not be possible in every circumstance.

#### **Making every contact count**

Training staff in [Making Every Contact Count](#) will give them the confidence to have brief conversations with individuals about how to improve their overall health and well-being. Where possible, this should be embedded across the whole system and throughout services. Making every contact count could include identification of people who may benefit from community rehabilitation input.

## System Priority Improvement: **Supporting people to stay well and maintain independence**

### Actions to take:

Clear point of access into the system for first and follow up care

- Secondary care staff need to know the local processes for referral into community based rehabilitation services
- Embed making every contact count across the system so when the need for rehabilitation is identified outside of secondary care, patient's can be referred easily into appropriate services to prevent deterioration
- Consider how 111 can support access to services.

Ensure care coordination/ navigator's are available for signposting to ongoing support

- Having a network of care coordinators / facilitators / equivalent role can help support patient journeys through the system.
- Provide contact details to individuals so that they have a point of contact if they require additional support.
- Particular consideration should be given to signposting and supporting specific population groups (such as older people and those from BAME groups) in order to overcome any barriers to accessing support services.

Local directory of services available

- Have a directory of local third sector and voluntary services available to support people to stay independent as long as possible
- Share the directory of services with individuals to enable them to access support when they need it.

Modifiable risk factors

- [Alcohol](#)
- [Continence](#)
- [Falls](#)
- [Home Adaptations](#)
- [Keeping warm and getting ready for winter](#)
- [Mental Health](#)
- [Nutrition](#)
- [Smoking](#)
- [Social isolation and loneliness](#)
- [Work](#)

Embedded social prescribing

- Use the [social prescribing link worker](#) funding for primary care networks, to commission link worker support from existing social prescribing schemes
- Have a clear and easy referral process in place for all local agencies to be able to refer to social prescribing link workers

## System Priority Improvement: **Supporting people to stay well and maintain independence (continued)**

### Actions to take:

Increase access to services when in the community

- Provide the person with contact details (e.g telephone numbers) so that they can access services when they need them to maintain independence.
- Sign post patients to third sector or voluntary services in the community

Making every contact count

- Embed the culture of [Make Every Contact Count](#) across the local system.
- Utilise freely available [MECC training courses](#) for all staff

## System Improvement Priority: Prevention of escalation and restoration of previous function

It is inevitable that people will find themselves in a position where they need support to help them restore to previous function, maintenance or slow progression of deterioration. When this is the case, the system must be responsive on an individual needs basis, having easy access to rehabilitation services when required. Access must be seamless between and within services to support people appropriately. The [NHS Long Term Plan](#) also places a stronger focus and provision of rehabilitation in the community, especially for stroke survivors. People also need to be supported to self manage themselves and their conditions as this is also vital to prevent escalation of needs.

### Key areas for focus:

#### Access to a skilled assessment with clear rehabilitation plans and goal

People at risk of escalation of their condition(s) must have the opportunity to see a skilled professional as part of a multidisciplinary service to assess, plan and set goals with the individual for their personal rehabilitation needs. Where people have already been within services, having a 6 month review would be beneficial to assess whether they continue to require further treatment and to ensure that any services provided are appropriate to their needs.

#### Access to a rehabilitation programme

It must be easy for individuals and especially those from disadvantaged groups to be able to access a programme of rehabilitation when needed. This should be in the setting and format the individual requires. For some forms of rehabilitation, group programmes may be beneficial as this provides social interaction as well as the rehabilitation offer. Adherence must be encouraged by, for instance, having programmes available that are readily accessible in the community. Local programmes also need to be responsive to people's fluctuating needs as the rehabilitation pattern can be different to those with progressive conditions.

#### Identification of individuals at risk of deterioration

Finding people who would benefit from community rehabilitation and those who are at risk of their condition(s) escalating is important. This comes from knowing your population and their community rehabilitation needs, and having system wide strategies to recognise those in need of formal rehabilitation.

#### Implement a patient passport for reviews

A patient passport is an approach where the patient takes their passport to each service to enable care coordination between services, and ensure that when moving to a new service then individuals needs and preferences are taken into consideration.

## System Improvement Priority: Prevention of escalation and restoration of previous function

### Actions to take:

Access to a skilled assessment with clear rehabilitation plans and goal

- Ensure that each patient has a clear assessment plan that includes their aims and goals for recovery. The plan needs to be clearly communicated with the individual to ensure they understand its content (this is linked to personalised care and shared decision making).
- Review the care assessment plan on a regular basis and ensure goals and aims are updated as appropriate.
- Rehabilitation plans should also include self management strategies to support people to recover and stay well in the longer term.

Ease of access to a rehabilitation programme

- Clear referral processes into community rehabilitation services that are known across the system
- Support individuals, and their carers, to know how they can refer themselves back into to services when they need to and as their needs change.
- Particular consideration should be given to supporting particular groups (e.g older people, those with long-standing disabilities and those from BAME groups) to be able to access rehabilitation services when they need them.

Identification of individuals at risk of deterioration

- Have agreed protocols in place to monitor patients on an ongoing basis so that any changes in functional ability, independence, or changing social care needs are recognised and acted upon appropriately.
- Ensure that the family and carers voice is heard if they suggest signs of deterioration have been noticed.

Implement a patient passport for reviews

- Use standard templates across your local system for the patient passport that is known and shared across all services.
- Collect the information within the passport in consultation with the patient, their family and any other carers and professionals involved in caring and supporting them.
- Encourage individuals to bring their passport with them to all appointments to ensure that it can be updated with any changing needs.

## **System Improvement Priority: Supporting the hospital/ community interface**

When people get to point where hospital admission is a risk, it is important to have strategies in place to support people in the community. Community rehabilitation has an integral part to play to support this point in the pathway. Equally when patients are 'stepping down' from hospital care they must have seamless access to a range of community rehabilitation services where required to maximise recovery and support self-management.

### **Key areas for focus:**

#### **Services in place for crisis management**

People with ongoing health and care problems will sometimes hit a crisis point. As part of the response to a crisis it is important to provide appropriate rehabilitation and support at these times to prevent deterioration.

#### **Urgent response in recognition of deterioration**

Along with services for crisis management, there must be strategies in place to recognise who and when people will require urgent interventions to arrest deterioration.

#### **Integrated commissioning to ensure seamless transition between acute and community care**

When people move into acute care and step down - how they move between the services must be a key consideration. Ensure that communication of an individual's needs and goals occurs across different service boundaries. Patient passports are a tool that could support this. After acute stays, timely community rehabilitation must be initiated and aligned to the individual's needs.

#### **Clinical expertise available for both emergency situations or for specialist input (eg neuro rehab)**

There will be times where generic rehabilitation services are not appropriate and a patient requires specialist input into their care. Specialist expertise should be prioritised for those patients who need it most. This could be resourced at a local level if available, or via a hub and spoke model of service delivery.

#### **Availability of 7 days services**

It is recognised that, for services that support crisis, and/or reduce the immediate risk of deterioration, timely response, including availability over 7 days where appropriate, is important. The [Long Term Plan](#), as part of the [Ageing Well programme](#), commits to delivering access to community crisis response services within 2 hours and reablement care within 2 days where clinically appropriate by 2023/24. Services should work towards meeting these objectives in alignment with the Ageing Well programme.

## System Improvement Priority: Supporting the hospital/ community interface

### Actions to take:

Services in place for crisis management

- Have a recognised rapid or crisis response service in place that is easily accessible when needed.

Urgent response in recognition of deterioration

- Having embedded recognition and response systems in place can support staff to promptly, accurately and reliably recognise patients whose condition is deteriorating clinically and to respond appropriately to stabilise the patient.

Integrated commissioning to ensure seamless transition between acute and community care

- Have clear protocols in place to support transition between acute and community care.
- Ensure that all involved in transition are aware of the agreed protocols and processes to ensure seamless transition.

Clinical expertise available for both emergency situations and for specialist input (e.g neuro rehab)

- Ensure that staff have appropriate contact details available when they need to seek specialist expertise and advice in urgent situations
- Have agreed access routes and clear referral pathways back into specialist services when needed.

Availability of 7 days services

- Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week.
- Services should work towards meeting the objectives in The Long Term Plan, as part of the Ageing Well programme, that commits to delivering by 2023/24 access to community crisis response services within 2 hours and reablement care within 2 days where clinically appropriate.



## **System Improvement Priority:** Integrated approach to commissioning across the whole system (including health, social, education and third sector)

Commissioning community rehabilitation requires understanding of where it integrates into a system. This is in relation to other rehabilitation services, so that seamless transitions of care occur and information is shared effectively. It is important when doing this to support all in the system including patients and professionals who come into contact and work in rehabilitation services.

### **Key areas for focus:**

#### **Commission community rehabilitation in the context of the whole system**

When commissioning community rehabilitation it must be done across the whole system to address the needs of individuals where they need it. This includes bed based, care home based, group rehabilitation and home based community rehabilitation.

#### **Have seamless transition between services**

When moving between services including moving into and out of hospital care, this move should be seamless. It involves communication of individuals needs, preferences and goals. This also must be timely, as early intervention from community rehabilitation is known to be more beneficial.

#### **Involve patients, carers and stakeholders across the system when commissioning community rehabilitation**

Co-produced community rehabilitation systems are essential to ensure they are built around the needs of patients and their carers.

#### **Have one patient record and ensure consistency of data and measures**

Having a single patient record, such as outlined within the [Local Health and Care Record Exemplars](#) programme, will support transitions of care and provide a seamless system approach. Supporting the use of the enhanced summary care record is a way to further support this. Strategies to ensure coding practices are appropriate are important to promote.

## System Improvement Priority: Integrated approach to commissioning across the whole system (including health, social, education and third sector)

### Actions to take:

Commission community rehabilitation in the context of the whole system

- Work with all partners across the system, including the NHS, the local authority, voluntary and community organisations to ensure that the community rehabilitation services are joined up across the system.
- Ensure that there are clear lines of communication and referral processes between organisations to ensure that patients do not get lost within the system

Have seamless transition between services

- Early and ongoing assessment and identification of rehabilitation needs can support timely planning and interventions to improve outcomes and ensure seamless transition.
- Have clear protocols and processes in place that are agreed across services to ensure seamless transition between and within services
- Ensure that all staff and services are trained and aware of all processes and protocols that are in place for transition
- Have seamless communication between hospitals and the new care setting.
- Have a shared and integrated system approach to supporting transfer of care

Involve patients, carers and stakeholders across the system when commissioning community rehabilitation

- Ensure that dialogue takes place between commissioners, providers, clinicians and service users to examine current service delivery and whether this meets the needs of the local population.
- Utilise patient and carer experience feedback when redesigning services
- Ensure that for those with cognitive disabilities i.e. those with communication and cognitive deficits, that technological support is considered when commissioning community rehabilitation services.

Have one patient record and ensure consistency of data and measures

- Community services can benefit from having access to the enhanced summary care record.
- Staff of all services should routinely access the enhanced summary care record (or equivalent) to support patient care

## System Improvement Priority: Match workforce to population needs

This section links to the identification and stratification section of this toolkit. There is a requirement for a system to understand what their population needs are around community rehabilitation and how and where those needs could best be met. Understanding this then supports the alignment of workforce to be responsive and provides access to people and services when they require it. Some areas to focus on for workforce are detailed here.

### Key areas for focus:

#### **Workforce to have multidisciplinary skill mix with broad knowledge base**

Where multidisciplinary teams are being commissioned to deliver rehabilitation services, these should take into account the needs of the population. Possible generic skills that each profession within the MDT can undertake should be considered along with the specialist skills they can provide.

#### **Workforce to be integrated and locally based within community & primary care settings**

Having an integrated community rehabilitation workforce for community and primary care improves coordination between services and access to services for patients when they need it. Consider the space that MDT's require and that face to face time is important for team members to support one another.

#### **Workforce mapping (capacity and location) – aligning to population needs**

Mapping of the workforce should be done in response to the needs and location of the populations who would benefit from any level of community rehabilitation. This is linked to capacity and demand planning across the whole system. Workforce benchmarking data for intermediate care can be accessed from [here](#).

#### **Multidisciplinary teams require defined leadership**

Multidisciplinary teams that provide community rehabilitation should have leadership that is defined and provides a coordinated approach. Leadership roles in community rehabilitation services can be undertaken by any professional with the appropriate leadership skills for the position. Support for leadership development must be factored in to support leaders.

#### **Capabilities and competencies**

Capability and competency analysis should be undertaken for MDT's to ensure that professionals are being supported to develop skills that are aligned to the needs of the population they support, this will also support staff development and career development – which is also a key commitment in the [NHS Long Term Plan](#). Ensuring that MDT members have face to face time with one another will support informal development which is also an important aspect.

## System Improvement Priority: Match workforce to population needs

### Actions to take:

Workforce to have multidisciplinary skill mix with broad knowledge base

- Multi-disciplinary teams need to understand each professional's role and responsibilities
- Relevant CPD needs to be available to broaden knowledge and contribution of the workforce.
- Access to rehabilitation should be based on the occupational needs of the individual, group or community.
- Rehabilitation staff should be employed from health, social care and mental health services to offer tailored, individual support to people and to provide expertise, advice and guidance to the wider multidisciplinary team.

Workforce to be integrated and locally based within community & primary care setting

- MDTs can work best when there is space for them to come together.
- Have regular face to face meetings

Workforce mapping (capacity and location) – aligning to population needs

- Undertake a review of the existing workforce to understand the current availability of skills/ skill mix.
- Map the skills required to meet the current and future demand of rehabilitation services within your system to identify any gaps
- Use technology that interfaces across providers to demonstrate workforce capacity.
- Implement job planning for AHPs to ensure workforce capacity is understood and matched to patient's needs, delivering quality outcomes.
- Benchmark your intermediate care workforce based on the results from the [National Audit of Intermediate Care](#)
- Support implementation of electronic tools to effectively and transparently plan and deploy the workforce (in line with the expectation that all trusts will have software in place to support the electronic deployment of clinical staff by 2021 as outlined in the [NHS Long Term Plan](#)).

Multidisciplinary teams require defined leadership

- Have strong leadership and accountability at all levels – with effective communication.
- Ensure individual professions within the MDT also have strong clinical and professional leadership out with the MDT leadership

Capabilities and competencies

- Teams are recommended to employ allied health professionals (AHPs) at different levels of banding/staffing to ensure a range of experience and expertise is available to support staff development and retention.

## System Improvement Priority: Improving data for rehabilitation services

Data to understand and measure both operational activity as well and outcome is essential to support effective community rehabilitation services. There is opportunity to improve data from community rehabilitation services. Local systems should complete the [Community Services Dataset](#) (CSDS v1.5) and any subsequent versions, in line with the [DCB1069 Information Standard](#). Participation in national audits, such as the [National Audit of Intermediate Care](#), will ensure that robust benchmarking data is available for local systems to use. The following key areas for focus provide some areas for systems to focus on to improve data for community rehabilitation services.

### Key areas for focus:

#### Local services to complete all fields in community services data set (to improve quality, robustness and completeness of data)

Completion of the community services data set ([CSDS v1.5](#)) will create a more robust data set. This data set is key to understanding opportunity and supporting improvement in community services where there is a current paucity of data.

#### Clear communication and data sharing across the system

It is important to have seamless communication and data sharing across the system to ensure that patients are receiving the best care, in the most appropriate place, for their needs. Sharing data across the system will enable the identification in unwarranted variations in care and will enable best practice to be shared and to drive up the quality of services provided.

#### Measurable quality and outcome measures built into local contracts

Approaches to contracting for community rehabilitation must have quality and outcome measures. Quality and how personalised care is delivered in community rehabilitation services should be included, with not just a sole focus on performance measures.

#### Participation in national audits and action on findings

Participation in national audits such as the [UK Rehabilitation Outcomes Collaborative \(UKROC\)](#), [Sentinel Stroke National Audit Programme \(SSNAP\)](#) or [National Audit of Intermediate Care](#) will provide a richer data set for community rehabilitation services, allowing more thorough understanding of improvement efforts, quality of services and patient outcomes.

## System Improvement Priority: Improving data for rehabilitation services

### Actions to take:

Local services to complete all fields in community services data set (to improve quality, robustness and completeness of data)

- Ensure that all publicly-funded community services are collecting and submitting their data to the [community services data set](#), as per their legal requirement as set out by the Health and Social Care Act 2012

Clear communication and data sharing across the system

- Data sharing agreements to be in place to ensure patient information can be shared across all services
- Embed a sharing and learning culture to support best practice and quality improvement

Measurable quality and outcome measures built into local contracts

- Agree what outcome measurement tools are appropriate for the client group, health condition and method of service delivery and how this data will be collected.
- Use the collected data to enable benchmarking with other services
- Undertake regular review and auditing of the commissioned contracts to support audit and quality improvement.
- Analyse the data to demonstrate whether inequalities have been reduced in terms of access to services, experiences of services and outcomes achieved

Participation in national audits and action on findings

- Ensure that participation in national audit is undertaken across services
- When the audit reports are available, use the findings from the audit to look at opportunities to improve patient care and outcomes

## **System Improvement Priority:** Timely access to technology, facilities and patient equipment

People with rehabilitation needs can have multiple functional problems and may therefore have complex equipment needs, over time the need for equipment may change. Regular assessment by the rehabilitation team can ensure the provision of equipment and adaptations is responsive to a person's changing needs. Providing equipment and adaptations without delay maximises the impact on the person's quality of life, allowing them to continue with usual activities and reduce the likelihood of harm from adverse events such as falls.

### **Key areas for focus:**

#### **Patients having equipment on discharge/in a timely manner for their needs**

If a patient is transferred between settings, it is a priority to supply any equipment required to maintain their level of function as quickly as possible.

#### **Equipment needs to be prescribed in relation to patient need and including reassessment**

People's needs and preferences should be considered when equipment is being provided to support them. It can be beneficial to follow up to ensure the equipment does suit the individual's needs.

#### **Support patients with (for example) cognitive and language impairments to use specialised technology and equipment**

Some patients may have very complex disabilities, which may impair their cognitive or language functions. Using communication aids or technological solutions will ensure that people are still able to express themselves, have meaningful interactions with others and be able to make their own choices.

#### **Use of digital/ apps/ technology – equip people/ staff with skills to use new technology**

Technology has great potential to help people with play a role in managing their own care, or that of others, from use of apps to online patient networks. Clinicians need to be aware of a patient's level of activation, health literacy and understanding, targeting information accordingly when giving patients advice on how to manage their condition and using digital tools to do so.

## System Improvement Priority: Timely access to technology, facilities and patient equipment

### Actions to take:

Patients having equipment on discharge/in a timely manner for their needs

- For those that require equipment, an assessment should be undertaken to ensure correct and appropriate equipment is supplied
- Ensure that any equipment supplied, including that which requires specific modifications (e.g. wheelchairs), is provided in an acceptable and appropriate time scale to the service user.
- The service user to be given adequate training and support to use their equipment

Equipment needs to be prescribed in relation to patient need and including reassessment

- Response times for supplying equipment, including that which requires specific modifications (e.g. wheelchairs), should be based on clinical prioritisation.
- Full training and support to be given on how to use the provided equipment
- Re-assess the service user within an agreed timescale to ensure the equipment provided continues to meet their individual needs .
- Ensure there is a protocol or referral process in place if a person needs to change/ upgrade their equipment.

Support patients with (for example) cognitive and language impairments to use specialised technology and equipment

- Ensure that there is clear routes for referral and accessing Augmentative and Alternative Communication (AAC) equipment when required
- A specialist AAC assessment can ensure the correct equipment is provided.
- Provide additional coordinated support from the AAC community and voluntary sector organisations to support patients, their families and carers on how to use their equipment

Use of digital/ apps/ technology – equip people/ staff with skills to use new technology

- Discuss with patients how they can best manage their condition at home.
- Assess the individual's ability to use digital tools and apps to self manage their condition.
- Signpost patients to available tools and apps.
- Ensure that staff are aware of digital tools and apps and how to use them

## System Improvement Priority: Person Centered Care

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs (NHS England, 2018).

### Key areas for focus:

#### Shared decision making

Personalised care planning should address the full needs of the individual, taking steps to address loneliness, isolation, healthy behaviours etc. The process should involve shared decision-making between the individual and the professionals supporting them, putting the patient at the centre of decisions about their own care. Voluntary sector organisations can also play an important role in effective care planning and providing follow up support. Additional support may be required for people with communication and/or cognitive impairments for example, to ensure they are able to communicate their preferences and to take a full and active role in decisions about their care.

#### Goal setting

Good rehabilitation services will enable the delivery of new local models of care that improve outcomes by putting the patient at the centre of their care, and focus on their goals.

#### Patient activation

Understanding people's ability to make informed decisions and choices about their health and rehabilitation requirements enables the rehabilitation team to provide the most useful and efficient support.

#### Personal health budgets

A personal health budget is planned and agreed between the individual and the local NHS team, giving the individual choice and control over healthcare and support. The individual may choose to use the budget to enhance opportunities for rehabilitation – for example, by employing a personal assistant to help them get "out and about" and improve their skills, independence, confidence in everyday situations and quality of life.

## System Improvement Priority: Person Centered Care

### Actions to take:

#### Shared decision making

- Ensure that people are actively involved in shared decision-making and are supported to undertake self-management for their condition
- Personalised care planning should address the [full needs of the individual](#), including wider social issues such as housing problems that may impact on health.
- Use patient decision aids to help people make informed choices about their healthcare and treatment options

#### Goal setting

- Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
- When setting goals ensure that they are clear, meaningful and measured and there is recognition that a person's goals may change over time.

#### Patient activation

- Measure patient activation levels (e.g. via PAM tool) to determine the realistic "next steps" for individuals to take in terms of self-management
- Provide training and education resources tailored to the levels of activation of different individuals within the population;
- Target resources and support at people with lower levels of activation who are less confident about their ability to manage their own care
- Address equality and health inequalities by targeting interventions at disadvantaged groups to increase their health literacy and patient activation.
- Support people to develop their capability to manage their own health and care by giving them information they can understand and act on, and providing them with support that is tailored to their needs.

#### Personal health budgets

- Ensure that patients, their families/carers are provided with information and support to access a personal health budget
- Provide patients with details of local support groups who can provide assistance in making benefits claims.

## System Improvement Priority: Experience of care

### Experience is important in a number of different, but related ways:

- **As a key part of providing high quality care:** Those providing health and care services view experience as a natural part of providing high-quality care, and a good experience is now seen as an important 'outcome' in its own right.
- **As a way of improving outcomes:** There is strong evidence about the links between experience and the other aspects of high-quality care (clinical effectiveness and safety).
- **As a way of indicating value for money and whether services are appropriate:** Only by understanding what people want from their services and continually focusing on their experiences will we truly be sure we are delivering value for money.
- **As a way of supporting staff engagement:** There is strong evidence to show the links between staff engagement and the experience of service users.

### Key areas for focus:

The poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them. Also, there are concerns about unfair discrimination in access to care. People who use our services have vital insights into their care and many are experts in managing their own conditions, genuine partnerships gives patients' parity of esteem with health professionals and both improve health outcomes and contribute to more cost-effective use of services. 'Good' experience of care will result in people who use our services being more engaged with their own healthcare, leading to improved patient/service user outcomes and productivity gains for NHS services

### Actions to take:

#### Improving the experience of care for people and their carers

- Ensure that there is a good understanding of the patient experience of rehabilitation pathways and facilitate ways of gathering and collating this information on a regular basis for individual sites and providers and across the whole system
- Services should use experience of care feedback from patients and carers on an ongoing basis to improve and develop services (e.g analysis of complaints)
- Involve third sector organisations to engage and support patients to access services, particularly in more disadvantaged groups, or those from BAME communities, who may not be accessing services
- Where local rehabilitation groups exist, ensure the patient voice properly represented
- Make information about patient experience available to providers of community rehabilitation services

# Guidance and best practice

This section contains all the relevant guidance, evidence and case studies aligned to each of this toolkit's system improvement priority and key areas for focus. It supports development of improvement actions when system priorities have been identified.

Key guidance referenced throughout document (see supporting slides for hyperlinks to each document)

## NHS England

- [NHS Long Term Plan Implementation Framework: system support offer](#)
- [Long Term Plan](#)
- [Commissioning Guidance for Rehabilitation](#)

## Ageing Well Programme

- [Ageing Well Programme](#)
- [Ageing Well Case Studies](#)

## NICE guidance

- [Transition between inpatient hospital settings and community or care home settings for adults with social care needs](#) (NG27)
- [Transition between inpatient mental health settings and community or care home settings](#) (NG53)
- [Intermediate care including reablement](#) (NG74)
- [Intermediate care including reablement](#) (QS173)
- [Transition between inpatient hospital settings and community or care home settings for adults with social care needs](#) (QS136)

For guidance on community rehabilitation for specific conditions, please refer to the related [NICE guideline pages](#) for each condition.

## Guidance

## Implementation and practical examples

System improvement priority: Population segmentation, identification and stratification

### System wide recognition when community rehabilitation is required

NHS England:

- [Commissioning Guidance for Rehabilitation](#)
- [Electronic Frailty Index FAQs](#)
- [Are you at risk of falling test](#)

Enderby, P. and J. Stevenson (2000). "What is Intermediate Care? Looking at Needs." [Managing Community Care](#) 8(6): 35-40.

Enderby, P. and D. Wade (2001). "Community rehabilitation in the United Kingdom." [Clinical Rehabilitation](#) 15: 577-581

[Macmillan Cancer Rehabilitation Pathways](#) – Although designed for cancer patients there are generic pathways that cover rehabilitation needs.

Northumbria Healthcare NHS Foundation Trust: [Development of the 'Avoiding Falls Level of Observation Assessment Tool'](#)

### Embedded approaches to population segmentation and/or stratification based on symptoms, function and need

NICE NG56: [Multimorbidity: clinical assessment and management](#)

NHS England Guidance: [Supporting routine frailty identification and frailty through the GP Contract 2017/2018](#)

NHS England:

- [Ageing Well Programme](#)
- [Ageing well and supporting people living with frailty](#)
- [Electronic Frailty Index FAQs](#)
- [Using case finding and risk stratification: A key service component for personalised care and support planning](#)

ARUK - [Providing physical activity interventions for people with musculoskeletal conditions report](#). Musculoskeletal physical activity commissioning pyramid (pg26)

[British Geriatric Society Blog - Developing an Electronic Frailty Index \(eFI\)](#) – includes information on how the eFI is being used and also some practice examples.

CSP Innovations Database:

- [Multimorbidity Rehabilitation- The Sustainable Way Forward – a tiered approach to rehabilitation](#)
- [Using ANGEL taxonomy to triage referrals in Cereidigion community physiotherapy](#)

Keele University - [STarT MSK Tool](#)

Turner-Stokes, L. Disler, R. and Williams, H. (2007): [The Rehabilitation Complexity Scale: a simple, practical tool to identify 'complexspecialised' services in neurological rehabilitation \(Appendix 1\)](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Population segmentation, identification and stratification (continued)**

### Undertake capacity and demand planning

NHS England: [Demand and Capacity programme](#)

NHS England & NHS Improvement: [E-rostering the clinical workforce: levels of attainment and meaningful use standards](#)

NHS Improvement: [Nursing and midwifery e-rostering: a good practice guide](#)

NHS England: [Demand and Capacity models](#)

Chartered Society of Physiotherapy Innovations Database: [ANGEL taxonomy to stream referrals](#)

Sussex Community NHS Foundation Trust: [Improving workforce visibility through e-rostering](#)

Leicestershire Partnership NHS Trust: [A training programme to optimise use of e-rostering systems](#)

### System wide education to support recognition of community rehabilitation needs

NHS England: [How to ensure the right people, with the right skills, are in the right place at the right time](#)

[Making Every Contact Count, How NICE resources can support local priorities](#) (NICE)

System improvement priority: **Supporting people to stay well and maintain independence**

### Clear point of access into the system for first and follow up care

NG74 [Intermediate care including reablement](#) section 1.2

NICE [Pathways](#) related to single point of access

NICE pathway information on [self referral](#) (lifestyle weight management section and depression in children and young people)

NHS Sandwell - [Integrated Care Services \(iCares\). Transforming and Integrating Community Services within admission avoidance, care management and community rehabilitation services](#)

[Broadening the workforce – using direct access to physiotherapy as an alternative to seeing a GP](#)

Chartered Society of Physiotherapy Innovations Database:

- [Self-referral option for back class in the community](#)
- [MSK SPoR in Primary Care](#)
- [Discharge to assess service](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence**

**Ensure care coordination/navigator's are available for signposting to ongoing support**

NICE:

- QS132 [Social care for older people with multiple long-term conditions](#) statement 3
- NG21 [Home care: delivering personal care and practical support to older people living in their own homes](#) section 1.3
- NG22 [Older people with social care needs and multiple long-term conditions](#)
- NICE Pathway information on [care coordinator](#)

NHS England [Social prescribing and community-based support. Summary guide](#)

Stroke Association:

- [Stroke Recovery Service](#)
- [The value of our services: Rebuilding lives after stroke](#)

## Local directory of services available

NHS England Quick Guide – [Improving Access to Urgent Treatment Centres using the Directory of Services](#)

NHS England [Social prescribing and community-based support. Summary guide](#)

[NHS Choices](#): Your complete guide to conditions, symptoms and treatments, including what to do and when to get help

- Patient information on: [Occupational therapy in rehabilitation](#), [Patient information on Physiotherapy](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Alcohol:

NICE Guidelines relating to alcohol use:

- PH24 [Alcohol-use disorders: prevention](#)
- CG100 [Alcohol-use disorders: diagnosis and management of physical complications](#),
- CG115 [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#)
- NG50 [Cirrhosis in over 16s: assessment and management](#)
- QS83 [Alcohol: preventing harmful use in the community](#)
- QS11 [Alcohol-use disorders: diagnosis and management](#)

Public Health England:

- [Alcohol: applying All Our Health \(2019\)](#)
- [The public health burden of alcohol: evidence review \(updated Aug 2018\)](#)
- [Older people and alcohol misuse: helping people stay in their homes \(2016\)](#)

#### Continence

NICE:

- CG49: [Faecal incontinence in adults: management](#)
- QS54: [Faecal incontinence in adults \(QS54\)](#)
- QS77: [Urinary incontinence in women \(QS77\)](#)
- CG148: [Urinary incontinence in neurological disease: assessment and management \(CG148\)](#)

CSP Innovations Database:

- [Falls assistant tool](#)
- [Functional restoration service](#)
- [Multimorbidity rehab](#)
- [Cancer recovery and exercise](#)

Health Education England:

- [New E-Learning programme](#) (to support CQUIN)
- [Video clips from E-Learning](#)
- [Existing E-learning programmes](#)

NHS England:

- [CQUIN Guidance](#)
- [CQUIN Indicator Specification](#)
- [Health Matters](#) (to support CQUIN)

Public Health England:

- [Knowledge Hub \(forum and resource library\)](#)
- [Referral Pathway Guidance](#)
- [Local alcohol services and systems improvement tool](#)

Liverpool Women's Hospital NHS Foundation Trust (2015): [Primary and secondary care for women with urinary incontinence – under one roof](#)

Royal Cornwall Hospitals NHS Trust (2015): [Management of Urinary Incontinence in females: Are we really NICE?](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Falls:

##### NICE

- CG161: [Falls in older people: assessing risk and prevention](#)
- QS86: [Falls in older people](#)
- [NICE Impact: falls and fragility fractures](#)
- [Preventing falls in older people overview](#)

##### Public Health England:

- [Falls and fractures: consensus statement and resources pack](#)
- [Falls prevention: cost-effective commissioning](#)
- [Falls: applying All Our Health](#)

Royal College of Occupational Therapists (2020) [Occupational therapy in the prevention and management of falls in adults \(2nd ed\)](#)

#### Home Adaptations

NHS England: [Information on Home adaptations](#)

Disabled Living Foundation: [Factsheets on Home Adaptions](#)

Independent Age: [Advice on Home Adaptions](#)

[Dudley Falls Prevention Service \(2019\)](#)

Lincolnshire Community Health Services (2019): [Fit for Falls - Falls prevention across the system](#)

Ashford and St Peter's Hospitals NHS Foundation Trust (2018) [Falls Prevention Exercise and Education Programme](#)

Oldham Community Leisure and Age UK Oldham (2018) [Oldham Exercise Falls Prevention Service](#)

Oldham Community Leisure and Age UK Oldham (2018) [Oldham Exercise Falls Prevention Service](#)

East Midlands Ambulance Service NHS Trust (2016) [Crisis response falls team: reducing admissions and repeat falls](#)

Portsmouth Hospitals NHS Trust (2013) [Patient information leaflets about preventing falls in hospital and the use of bedrails](#)

University Hospitals Birmingham NHS Foundation Trust (2013) [Multifactorial interventions can reduce harm from falls in Acute Hospital settings](#)

Thurrock Council (2019): [A strengths based approach to delivering the Disabled Facilities Grant](#)

NICE: Frailty and Sustainability Transformation Resource - [Improving care and support for people with frailty](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Keeping Warm and Staying Well for Winter:

NICE:

- NG6: [Excess winter deaths and illness and the health risks associated with cold homes](#)
- QS 117: [Preventing excess winter deaths and illnesses associated with cold homes](#)

NHS England: [Keep warm, keep well](#)

Public Health England:

- [Cold weather plan for England](#)

#### Mental health:

All NICE products on [mental health and wellbeing](#)

NHS Health Education England/ UCLPartners: [Breaking Down the Barriers](#)

NHS Health Education England/ PHE: e-learning on [Community-centred approaches to health improvement](#)

Public Health England:

- [Prevention concordat for better mental health](#)
- [Wellbeing and mental health: applying All Our Health](#)

#### Nutrition:

All NICE products on [diet, nutrition and obesity](#)

- CG32: [Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition](#)
- QS24: [Nutrition support in adults, statement 1, Screening for the risk of malnutrition](#)

NHS Choices:

- [Eat Well](#) eight tips for healthy eating.
- [Advice on identifying and managing malnutrition](#)
- [Keep your bones strong over 65](#)

Public Health England:

- [Keep Warm, Keep Well booklet](#)
- [Top tips for keeping warm and well](#)

#### Mental health:

NHS Cambridgeshire and Peterborough [Primary Care Mental health Service \(PRISM\)](#) (2018)

[Meeting the need: what makes a 'good' JSNA for Mental Health?](#), by the Centre for Mental Health. This report explores how 5 local councils across England went about understanding the mental health needs of their communities, and taking action to meet them more effectively.

[Better mental health: JSNA toolkit](#)

#### Nutrition:

Chesterfield Royal Hospital NHS Foundation Trust (2018) [The North Derbyshire Nutrition Support Project: Increasing appropriate Oral Nutrition Supplement prescriptions](#)

Cambridgeshire Community Services NHS Trust (2018) [Using Nutrition Support NICE Quality Standards as a basis to improve management of malnourished care home residents with a Food First approach](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Nutrition continued:

Public Health England:

- [The Eat Well Guide](#)
- [Impact assessment - Helping older people maintain a healthy diet: A review of what works \(2017\)](#)
- [Patterns and trends in adult diet \(2017\)](#)

[Malnutrition Taskforce](#) - a focus on malnutrition in later life

Social Care Institute for Excellence: [Nutritional care and older people](#) standards of nutritional care for older people.

Royal Voluntary Service: [Eating well when you are over 70](#)

World Health Organisation [Defining the specific nutritional needs of older persons](#)

#### Smoking:

Care Quality Commission: [Brief guide: Smokefree policies in mental health inpatient services](#)

National Centre for Smoking Cessation and Training:

- [Very Brief Advice training module](#)
- [Smoking cessation and smokefree policies:](#)

All NICE products on [smoking and tobacco](#)

NICE Pathways:

- [Stop smoking intervention and services](#)

#### Nutrition continued:

Lancashire Care NHS Foundation Trust (2014) [Auditing NICE Quality Standard 24 on Nutrition](#)

Walsall Healthcare NHS Trust (2011)

- [Prevalence of malnutrition in nursing, care and residential homes in Walsall](#)
- [Pilot to improve the appropriate prescription of oral nutritional supplements within the Walsall area](#)

GWH NHS Foundation Trust & NHS Swindon (2011) [Clinical and Cost Effective Prescribing of Oral Nutritional Supplements for Adults in the Community](#)

#### Smoking:

NICE: [return on investment tool](#) for tobacco

South London and Maudsley NHS Foundation Trust: [Journey to become Tobacco-free](#) (2017)

Public Health England:

- [Stop smoking options: guidance for conversations with patients](#)
- [Stop smoking services: models of delivery](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Smoking cont:

NICE guidelines:

- NG92: [Smoking cessation interventions and services](#)
- PH48 [Smoking: acute, maternity and mental health services](#)
- PH45 [Smoking: Harm reduction](#)
- QS92 [smoking: harm reduction](#)
- QS82 – [smoking: reducing and preventing tobacco use](#)
- QS43 [smoking: supporting people to stop](#)

Public Health England

- [Tobacco and smoking: policy, regulation and guidance](#)
- [Health matters: Stopping smoking – what works?](#)

#### Social isolation and loneliness:

NICE:

- NG32: [Older people: independence and mental wellbeing](#)
- QS137 [Mental wellbeing and independence for older people](#)

NHS England: [Loneliness in older people](#)

Department for Digital, Culture, Media & Sport :  
[Community Life Survey: Focus on Loneliness](#)

#### Smoking cont:

Public Health England:

- [Stop smoking options: guidance for conversations with patients](#)
- [Stop smoking services: models of delivery](#)

#### Social isolation and loneliness:

[Befriending Services](#) (Age UK), tackling loneliness in later life through befriending, or ‘visiting’ services, where a volunteer visits or talks to an older person once a week in their own home.

Independent Age: [If you’re feeling lonely: How to stay connected in older age](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Modifiable risk factors

#### Work:

#### NICE:

- NG146 [Workplace health: long-term sickness absence and capability to work there is also:](#)
- NG13 [Workplace health: management practices](#)
- PH22 [Mental wellbeing at work](#)
- PH13 [Physical activity in the workplace](#)
- PH5 [Smoking: workplace interventions](#)

**NHS Networks:** [Mapping Vocational Rehabilitation Services for People with Long Term Neurological Conditions](#)

#### Work:

Leicestershire Fit for Work service (LFFWS) (2011):

[Moving vocational rehabilitation closer to primary care to prevent long term sickness absence](#)

### Embedded social prescribing

The Kings Fund, 2017 – [What is social prescribing?](#)

NG32 [Older people: independence and mental wellbeing](#)

NHS England [Social prescribing and community-based support. Summary guide](#)

Royal Society for Public Health: [Driving forward social prescribing: A framework for Allied Health Professionals](#)

Royal Society for Public Health: [Driving forward social prescribing: A framework for Allied Health Professionals](#)

All Party Parliamentary Group report [Creative Health](#)

The Work Foundation, Lancaster University (2017) [Social prescribing: a pathway to work?](#)

Royal College of GPs: [Spotlight on the Ten High Impact Actions](#)

Bristol – [Ways to Wellbeing Social Prescribing Service](#)

NICE Endorsed Resource: [Social Prescribing Assessment Tool](#)

York CVS: [Social Prescribing](#)

[Healthy Prestatyn Iach Team](#)

Healthy London Partnership:

- Social prescribing animation
  - A guide to implementing social prescribing in London
- University of Westminster:

- Making Sense of Social Prescribing
- A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications

Social prescribing – [a guide for local authorities](#)

### Increased access to services when in the community

NHS England [Social prescribing and community-based support. Summary guide](#)

**NHS Choices:** Your complete guide to conditions, symptoms and treatments, including what to do and when to get help

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting people to stay well and maintain independence (continued)**

### Making every contact count

Health Education England

- [Making Every Contact Count](#)
- [Training in MECC](#)

NICE:

- PH6: [Behaviour change: general approaches](#)
- PH49: [Behaviour change: individual approaches](#)

Public Health England:

- [Making Every Contact Count: Practice Resources](#)

CSP Innovations Database:

- [Making every contact count model of practice](#)
- NHS North - [Making Every Contact Count: implementing NICE behaviour change guidance](#)
- NHS Midlands & East - [An Implementation Guide and Toolkit for Making Every Contact Count](#)

NICE:

- Sustainability and transformation resource: [Making Every Contact Count](#)
- Making every contact count: [how NICE resources can support local priorities](#)
- [Improving care and support for people with frailty](#)

PHE: [Developing plans to implement MECC in NHS organisations in Cheshire and Merseyside](#)

System improvement priority: **Prevention of escalation and restoration of previous function**

### Access to a skilled assessment with clear rehabilitation plans and goal

NICE CG162: Stroke rehabilitation in adults: [Planning your rehabilitation](#) NHS Greater Glasgow and Clyde: [Goal Setting Tool](#)

NHS England: [Universal Personalised Care: Implementing the comprehensive model](#)

### Access to a rehabilitation programme

NHS England: [Commissioning Guidance for Rehabilitation](#)

Wessex Strategic Clinical Networks: [Rehabilitation is Everyone's Business: Principles and expectations for good adult rehabilitation](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Prevention of escalation and restoration of previous function (continued)**

### Identification of individuals at risk of deterioration

NICE:

- NG50: [Acutely ill adults in hospital: recognising and responding to deterioration](#)
- NG56: [Multimorbidity: clinical assessment and management](#) see **recommendation 1.3** How to identify people who may benefit from an approach to care that takes account of multimorbidity and **recommendation 1.4** How to assess frailty

CSP Innovations Database:

- [Educating staff to identify frailty](#)
- [Early identification of non-medical patients in ED](#)
- [Triaging community referrals](#)

Portsmouth Hospitals NHS Trust (2011): [Improving the detection and response to patient deterioration](#)

### Implement a patient passport for reviews

NHS England:

Practical guidance supporting the 2019-20 CQUIN: [Six month reviews for stroke survivors](#)

Stroke Association:

- [Stroke Recovery Passport](#)
- [Six month Post-stroke Reviews – service specification](#)

George Eliot Hospital NHS Trust (2011) [The HEALTH Passport: Helping Everyone Achieve Long Term Health](#)

NHS North West (2013): [North West Patient Leaders Programme and NW COPD Patient Passport](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting the hospital/ community interface**

### Services in place for crisis management

NICE:

- NG51: [Sepsis: recognition, diagnosis and early management](#)

NG74:

- [Referral into intermediate care, recommendation 1.4.6](#)
- [Crisis response, recommendations 1.5.4-1.5.6](#)

NICE Pathways:

- [Intermediate care including reablement](#)
- [Pathways](#) relating to crisis management

CSP Innovations Database:

- [Community Respiratory Team](#)
- [COPD ESD](#)
- [Therapists in A&E](#)
- [Stroke ESD](#)
- [Transformation of therapy services \(including ESD for #NOF\)](#)

Sandwell and West Birmingham Hospitals NHS Trust (2017): [Integrated Care Services \(iCares\). Transforming and Integrating Community Services within admission avoidance, care management and community rehabilitation services](#)

NICE: [Transforming urgent and emergency care sustainability resource](#)

### Urgent response in recognition of deterioration

NICE:

- CG50: [Acutely ill adults in hospital: recognising and responding to deterioration](#)
- NG74: [Intermediate care including reablement](#) see **section 1.5.1**, entering intermediate care
- [NG51: Sepsis: recognition, diagnosis and early management](#)

[Comprehensive Geriatric Assessment \(CGA\)](#) (CGA Toolkit), a tool for undertaking multidimensional holistic assessment of an older person. It considers health and wellbeing and formulates a plan to address issues which are of concern to the older person.

[Recognising frailty in an emergency situation](#) (British Geriatric Society)

[Ambulatory emergency care guide](#) (NHS Improvement)

[NEWS2](#) (Royal College of Physicians), National Early Warning Score.

[Livewell South West](#), link to the crisis response team website including referral form and information leaflets.

[Frailty Interface team in emergency care](#) (Acute Frailty Network)

[Crisis response falls team: reducing admissions and repeat falls](#) (NICE), quality and productivity case study from East Midlands Ambulance Service NHS Trust.

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting the hospital/ community interface (continued)**

### Integrated commissioning to ensure seamless transition between acute and community care

NHS England: [Quick Guide: Allied Health Professions enhancing Health in care homes](#)

The Trauma and Research Network (TARN):  
[Major Trauma Rehabilitation Prescription \(2019\)](#)

Sandwell and West Birmingham Hospitals NHS Trust (2017) [Integrated Care Services \(iCares\). Transforming and Integrating Community Services within admission avoidance, care management and community rehabilitation services](#)

[Somerset Homefirst Scheme](#): offers patients who are healthy enough, and their families, tailored help to finish therapy at home, with personalised care reducing stays in hospital by up to ten days.

### Clinical expertise available for both emergency situations or for specialist input

#### CSP Innovations Database:

Advanced practice role:

- [Working with complex persistent pain](#)
- [Patient satisfaction and outcomes in MSK pain](#)
- [Advanced practitioner as first point of contact](#)
- [ESD stroke specialist rehab](#)
- [Community Respiratory Team](#)
- [COPD ESD](#)

[The Marie Curie Hospice Hampstead Therapy Team](#) is a specialist oncology and palliative care team providing personalised inpatient and outpatient rehabilitation to patients across Marie Curie

Hospice Hampstead and the Royal Free Hospital, - p27, Fig 8

[Move More Wandsworth](#) a community based exercise programme for patients with cancer diagnosis; p40, Fig 13

## Guidance

## Implementation and practical examples

System improvement priority: **Supporting the hospital/ community interface (continued)**

### Availability of 7 days services

NHS Improvement: [Seven day services in the NHS](#)

NHS England: [Seven Day Services Clinical Standards](#)

NHS Improvement: Implementing seven day hospital services [case studies](#)

CSP Innovations Database: [Community Respiratory Team](#)

Torbay and Southern Devon Health and Care NHS Trust (2016): [Providing a seven day stroke rehabilitation therapy service on the stroke unit](#)

Mid Cheshire Hospitals NHS Foundation Trust (2018) [Introducing therapy champions to improve the 24 hour approach to patient rehabilitation](#)

University Hospital South Manchester NHS Foundation Trust (UHSM) (2014) [The importance of seven day access for post myocardial infarction patients to cardiac rehabilitation specialists in an acute trust](#)

System improvement priority: **Integrated approach to commissioning across the whole system**

### Commission community rehabilitation in the context of the whole system

NHS England: [Commissioning Guidance for Rehabilitation](#)

Kings Fund: [Reimagining community services: making the most of our assets](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Integrated approach to commissioning across the whole system**

### Having seamless transitions between services

#### NICE:

- NG27: [Transition between inpatient hospital settings and community or care home settings for adults with social care needs](#)
- NG53 [Transition between inpatient mental health settings and community or care home settings.](#)

#### NHS England Quick Guides:

##### Improving Hospital Discharge:

- [Discharge to assess](#)
- [Improving hospital discharge to care sector](#)
- [Supporting patients' choices to avoid long hospital stays](#) – [Patient leaflet](#), [easy-read](#) and [policy document](#)
- [Sharing patient information](#)

##### Better use of care at home:

- [Health and housing](#)
- [Better use of care at home](#)
- [Sharing patient information](#)

**NICE Sustainability and transformation resource:**  
[Improving transfer of care](#)

#### CSP Innovations Database:

- [COPD ESD](#)
- [Discharge to assess service](#)
- [ESD stroke specialist rehab](#)

Bristol City Council / Bristol, North Somerset, South Gloucester CCG / Bristol Community Health (2019)  
- [Supporting best patient outcomes through a joint Discharge to Assess, Home First service](#)

NHS England: [Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders](#)

### Involve patients, carers and stakeholders across the system when commissioning community rehabilitation

#### NICE:

- NG44: [Community engagement: improving health and wellbeing and reducing health inequalities](#)
- QS 148: [Community engagement: improving health and wellbeing](#)

#### CSP Innovations Database:

- [Patient experience of physiotherapy input on a specialist heart unit](#)

### Have one patient record and ensure consistency of data and measures

[Local Health and Care Record Exemplars](#) programme  
[Summary Care Record \(SCR\)](#)

[Guidance for GPs](#) to use SCR to make more information available across care settings.

## Guidance

## Implementation and practical examples

System improvement priority: **Match workforce to population needs**

### Workforce to have multidisciplinary skill mix with broad knowledge base

The [Stroke Specific Education Framework](#) outlines core competencies for a range of professionals working with stroke survivors.

Health Education England:

- [Multi-professional framework for advanced clinical practice in England](#)
- [Advanced and consultant level national network \(advanced clinical practice and consultant roles\)](#)
- [Allied Health Professionals' Careers Resource](#)

NHS England: [Non-medical prescribing by allied health professionals](#)

NHS Improvement: [Clinical leadership — a framework for action](#)

RCOT: [The Career Development Framework: Guiding Principles for Occupational Therapy](#)

Skills for Health:

- [Musculoskeletal core capabilities framework](#)
- [Frailty Core Capabilities Framework](#)

CSP Innovations Database:

- [Multimorbidity Rehabilitation- The Sustainable Way Forward](#)
- [Early identification of respiratory impairment in motor neurone disease](#)

### Workforce to be integrated and locally based within community and primary care settings

Health Education England – [Rehabilitation Medicine training](#)

### Workforce mapping (capacity and location) – aligning to population needs

NHS Improvement:

[Allied health professionals job planning: a best practice guide](#)

NHS Benchmarking Network: [National Audit of Intermediate Care](#)

NHS England: [Demand and Capacity models](#)

CSP Innovations Database: [ANGEL taxonomy to stream referrals](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Match workforce to population needs (continued)**

### Multidisciplinary teams require defined leadership

NHS Improvement: [Creating a culture of compassionate and inclusive leadership](#)

CSP Innovations Database: [Leadership Transforming Therapy Services](#)

### Capabilities and competencies

NHS Improvement: [Clinical leadership — a framework for action](#)

RCOT: [The Career Development Framework: Guiding Principles for Occupational Therapy](#)

CSP Innovations Database: [CGA assessment training](#)

MECC Training:

- [Increasing healthy lifestyle conversations with patients in the community](#)
- [Developing an evidence-based Making Every Contact Count \(MECC\) model of practice](#)

System improvement priority: **Improving data for rehabilitation services**

### Local services to complete all fields in community services data set

NHS Digital:

- [DCB1069 Information Standard: Community Services Data Set](#)
- [The community services dataset \(the Why, the Who, the What and the When of the Community Services Data Set\)](#)
- [Community Services Data Set Readiness Assessment Tool](#)

### Measurable quality and outcome measures built into local contracts

NHS England – [Commissioning guidance for rehabilitation](#)

CSP Innovations Database: [Measuring Outcomes in MSK: Analysis of Practice and Recommendations for Development](#)

Healthy London Partnership (2017): [Cancer Rehabilitation Data Recommendation Report](#)

NICE Shared Learning Database:

- Greater Manchester Stroke Operational Delivery Network (2016): [Developing and implementing a set of outcome measures incorporating NICE Standards across the whole stroke care pathway in Greater Manchester](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Improving data for rehabilitation services (continued)**

### Participation in national audits – act on findings

National Audit Programmes:

- [National Asthma and COPD Audit Programme](#)
- [National Diabetes Audit Programme](#)
- [National Audit of Care at the End of Life \(NA-CEL\)](#)
- [Falls and Fragility Fracture Audit \(includes the Hip Fracture Database\) \(FFFAP\)](#)
- [Sentinel Stroke National Audit Programme \(SSNAP\)](#)

NHS Benchmarking Network: [National Audit of Intermediate Care](#)

CSP Innovations database:

- [Stroke rehabilitation quality improvement plan](#)

### System improvement priority: Timely access to technology, facilities and equipment

#### Patients having equipment on discharge/in a timely manner for their needs (link with Prog Neuro pathway recommendations)

NHS England – [Model Service Specification for wheelchair and posture services](#)

NHS England and Local Government Association  
[Integrated personal commissioning emerging framework](#)

NHS England [Wheelchair services dataset](#)

#### Equipment needs to be prescribed in relation to patient need and including reassessment

NHS England – [Personal wheelchair budgets](#)

NHS England : [Personal health budgets in action - series of films and patient stories](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Timely access to technology, facilities and equipment**

**Support patients with (for example) cognitive and language impairments to use specialised technology and equipment**

Stroke Association: [My stroke guide](#)

**Use of digital/ apps/ technology – equip people/ staff with skills to use new technology**

CSP Innovations Database:

- [The digital future of physiotherapy](#)
- [The Falls Assistant tool](#)

Stroke Association: [My Stroke Guide](#)

[AbilityNet](#) helps people of any age and with any disability to use technology to achieve their goals at home, at work and in education, providing specialist advice services and free information resources

System improvement priority: **Personalised care**

**Shared decision making (best interest decision making, capacity dependency)**

[Guidance on delivering personalised care and support](#) – contains a number of personalised care case studies

[NICE information on shared decision making](#)

NICE [Pathways](#) related to shared decision making.

[Shared decision making](#) (NHS England)

[MAGIC: shared decision making](#) (The Health Foundation)

[Improving decision-making in the care and support of older people](#) (Joseph Rowntree Foundation), how does risk and trust affect decision making in care of older people?

## Guidance

## Implementation and practical examples

System improvement priority: **Personalised care**

### Goal setting

NICE [Pathways](#) related to reablement

NG74 [Intermediate care including reablement](#)

QS74 [Head injury](#) statement 7

CSP innovations database:

[Implementation of a new goal-planning process in an intermediate neuro-rehabilitation unit](#)

Healthcare Improvement Scotland: [What matters to you?](#)

Institute for Healthcare Improvement: [What matters](#)

### Patient activation

NHS England:

- [Patient Activation Measure \(PAM\) - implementation quick guide](#)
- [Patient activation and PAM FAQs](#)
- [PAM Learning Set](#)

Health Foundation: [Reducing emergency admissions](#)  
[Unlocking the potential of people to better manage their long-term conditions](#)

### Personal health budgets

NHS England & Local Government Association:  
[Personal budgets, integrated personal budgets and personal health budgets Summary guide](#)

NHS England : [Personal health budgets](#)  
[An introductory video to Personal Health Budgets](#)

NHS England : [Personal health budgets in action - series of films and patient stories](#)

## Guidance

## Implementation and practical examples

System improvement priority: **Experience of care**

**Improving the experience of care for people and their carers**

### NICE

- CG138: [Patient Experience in Adult NHS Services: improving the experience of care for people using adult NHS services](#)
- NG86: [People's experience in adult social care services: improving the experience of care and support for people using adult social care services](#)
- CG136: National Quality Board: [Improving Experiences of Care: Our shared understanding and ambition](#) (2015)
- Sustainability and transformation resources on [Mental Health](#)

Department of Health & Social Care: [The Government's revised mandate to NHS England for 2018-19](#) – Objective 2: To help create the safest, highest quality health and care service.

### NHS England:

- [Commitment to Carers](#)

The Beryl Institute: [Patient Experience Resources](#)  
[A Coproduction Model - Coalition for Collaborative Care](#)

### NHS England:

- [Improving Experience of Care through people who use services](#) (2015)
- [An integrated approach to identifying and accessing Carer health and wellbeing](#) (2016)
- [Insight resources](#)
- [Always Events](#)

NHS Improvement: [Patient Experience Improvement Framework](#) (2018)

Patient Experience Network: [Case studies](#)

Picker: [Always Events: what have we learned so far?](#) (2018)

# Community Rehabilitation Self-Assessment Questionnaire

These self-assessment questions (SAQ) are designed to help local areas (including STPs, ICSs and PCNs) gain enhanced understanding of their community rehabilitation system. The NHS RightCare Community Rehabilitation Toolkit provides a benchmark to enable understanding of the key components of an rehabilitation system. The questions should be used alongside the Toolkit to facilitate discussion and identify improvement opportunities or exemplars of good practice. The SAQs have been developed in partnership with our stakeholders.

**Specifically these questions are designed to :**

- Assess the existing system provision of services and provide quality care for people living with rehabilitation needs
- Identify any current gaps in service provision and/or current opportunities to enhance or develop services/systems at a local level
- Consider future demand from any projected increase in prevalence based on current care models, using local intelligence alongside projected data to ensure accuracy and consistency.
- Assess the progress of any system improvements over time.

**Rating Key: 1 = Fully met, 2 = Partially met, 3, Not met, 4 = Not applicable**

Grey shaded questions are not rag rated but should be used to help in gathering supplementary information

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Population identification and segmentation based on symptoms, function and need	1. Have you completed a joint strategic needs assessment for community rehabilitation services within your system that identifies current and future demand of services and also addresses inequalities in access and outcomes? 2. Are you able to match different types of intervention with the different levels of community rehabilitation needs?	
Supporting people to stay well and maintain independence (Including modifiable risk factors).	3. Are there commissioned self-management education and services available within the local community? 4. Are robust feedback mechanisms in place between statutory services and third sector organisations? 5. Are all staff trained in the principles of making every contact count? 6. Do you have care coordinators/facilitators/ or equivalent role in place to support patients? 7. Do you provide patients with a point of contact if they require additional services? 8. Can your staff direct patients to local third sector or voluntary support groups? 9. Do your staff have a directory of what locally commissioned services are available? (e.g. smoking cessation or weight management)? 10. Do you have a social prescribing link worker in place?	

# Community Rehabilitation Self-Assessment Questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Prevention of escalation and restoration of previous function	<p>11. Do you have clear referral processes in place that are known across the system on how to access community rehabilitation services?</p> <p>12. Are patients able to refer themselves back into services if they need them to prevent deterioration or escalation of needs?</p> <p>13. Do you use patient passports across your system that is known by all services?</p>	
Supporting the Community : Hospital interface	<p>14. What systems do you have in place to recognise when a patients condition is clinically deteriorating and requires a rapid or crisis response?</p> <p>15. Do you have integrated multi-agency rehabilitation pathways in place, including where appropriate, availability of services seven days a week?</p>	
Decreasing admissions and supporting discharge	<p>16. Do you have agreed protocols, that are known by all, to support transition between acute and community care?</p> <p>17. Are there protocols in place to ensure seamless referral with specialist services when required?</p>	
Integrated approach to commissioning	<p>18. Are there clear lines of communication and referral processes between the different organisations to ensure optimal patient experience?</p> <p>19. Is there regular dialogue between commissioners, providers, clinicians and service users to evaluate current service delivery and ensure it meets the needs of the local population?</p> <p>20. Do community services/staff in your area have access to the enhanced summary care record to support patient care?</p> <p>21. Do you engage with service users when redesigning services to ensure that the patient experience is taken in to account?</p>	
Matched skilled workforce to population needs	<p>22. Do you undertake regular workforce mapping, including skill mix, and job planning to ensure that that you can meet the needs of your population now and in the future?</p> <p>23. Do you have a clearly defined professional leadership and accountability within your multidisciplinary rehabilitation team?</p> <p>24. Do you, or are you planning to move onto electronic deployment tools (e.g e-rostering) to effectively and transparently plan and deploy the workforce</p> <p>25. How are individual professions supported with strong clinical and professional leadership?</p>	

# Community Rehabilitation Self-Assessment Questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Improving data quality for rehabilitation services	<p>26. Is the Community Services Data Set (CSDS) embedded in you community services?</p> <p>27. How do you analyse and review the outputs from the CSDS?</p> <p>28. How do you ensure that sharing and learning on best practice is shared across your organisation/ services?</p> <p>29. Do you have a set of outcome measurement tools that are appropriate for the client group, health condition or method of service delivery available?</p> <p>30. Do you take part in all national audits? How do you ensure that you act on the results from audit reports?</p>	
Clear communication and data sharing across the system	<p>31. Do you have data sharing agreements in place to ensure that patient information can be shared across all services?</p>	
Timely access to technology, facilities and patient equipment	<p>32. Do you have protocols in place to ensure that equipment provided meets patient needs, is delivered within a specified timescale and can be updated as required?</p>	
Person centred care	<p>33. Are patients actively involved in shared decision-making and supported to self-manage their condition when appropriate?</p> <p>34. Do you provide patients and their families/carers with information and support to access a personal health budget?</p> <p>35. Do you provide patients with details of local support groups who can provide assist in making benefits claims?</p>	
Experience of care	<p>36. Do you have a mechanism in place to collect patient experience of rehabilitation services for individual sites and providers and across the whole system?</p> <p>37. Do you use the experience of care feedback from patients and carers on an ongoing basis to improve and develop services (e.g. undertake analysis of complaints)?</p> <p>38. Do you work with third sector organisations to engage and support patients to access services, particularly in more disadvantaged groups who may not be accessing services?</p> <p>39. Do you have patient voice representation on local rehabilitation groups (where they exist)?</p>	

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- [Age UK](#)
- [British Society of Rehabilitation Medicine](#)
- [The Chartered Society of Physiotherapy](#)
- [National Institute for Health and Care Excellence](#)
- NHS England and NHS Improvement Clinical Policy Unit
- [Macmillan Cancer Support](#)
- [MS Society](#)
- [Royal College of Occupational Therapists](#)
- [Royal College of Speech and Language Therapists](#)
- [Stroke Association](#)
- [Versus Arthritis](#)

