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COMMISSIONING GUIDANCE FOR REHABILITATION

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INTRODUCTION

Scope of this guidance

This guidance is intended for use by clinical commissioning groups to support them in commissioning rehabilitation services for their local population. It may also be of use to others with an interest in rehabilitation.

The document outlines:–

- What rehabilitation is, i.e. scope, breadth and depth.
- The components of good quality rehabilitation.
- How to know whether the services that are being commissioned are of good quality.
- How to compare rehabilitation services locally, regionally and nationally.

The guidance also provides access to a great many resources within its reference list, hyperlinks and comprehensive appendices.

The document will be reviewed in 2017/18.

I am Suzanne Rastrick, I am the Chief Allied Health Professions Chief Professional Officer for England, working in NHS England.

I have been a commissioner for two thirds of my career so I really understand how important it is to get population based planning right, particularly based in evidence.

I would like to introduce to you a new commissioning guide on rehabilitation and it sets out at population level the evidence and best practice across England that you will be able to use in a CCG to actually really understand how to commission the best rehabilitation services for your population.

It will also enable you to benchmark against other areas in England to see how you are performing in comparison.

I commend it to you.

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To introduce myself. From birth I have been diagnosed with muscular skeletal and neurological problems. Rehabilitation for me over the last 50 years has been a personal roundabout , jumping on and off over the years. As a patient representative locally, regionally and nationally it is now my responsibility as part of the national team to try and express the need, not only for patients, but for our whole NHS system to look in a different way around this important subject.

What do we all expect of our NHS? I mean the real basics. Having spoken to many people, those receiving treatment, their families and carers three words explain their basic needs. Diagnosis, treatment and rehabilitation. When I was asked to join the NHS England rehabilitation programme 2 years ago to re-establish how to enable individuals to get back to 'living their lives', I realised that not much had changed in culture and philosophy over time. Then the '5 Year Forward View' was published. I believed the rehabilitation pathway looking at the big picture around physical, emotional and mental health needs for individuals ran through this document. I also believed we should look at co-commissioning, collaborative and integrated commissioning with local authority, department for work and pensions and education to allow all of us a ' recovery and prevention' commissioning stream within all CCGs. I hope this guidance will be a starting point to enable commissioners to realise this ambition.

The pathway for this recovery and prevention commissioning is obviously complex just as we are as individuals however it is exciting, creative, using all sectors. At the heart is the empowerment through self-management of individuals, their families and carers. It is a change in philosophy and culture, it is us taking the NHS forward.

Whatever we call this type of commissioning, rehab, reablement, survivorship etc etc it is about people, not diagnosis. It is about you and me. **Jayne Pye**

Hello, my name is Amy Frounks. I am a service user that avidly tries to improve the care for others by being a member of NHS England Youth Forum and Young CDC alongside local groups, such as CAMHS participation.

I can vouch first hand, the difference that youth voice can make in NHS services. Children, young people and adults alike all have important views and experiences that can be inputted into the services they use. It makes significant sense to utilise these willing voices no matter what their ages are and that is why this guidance is so excellent, as they were constructed with the input of service users. Different user groups fed their views into this guidance, expressing their perspectives from their rehabilitation to allow us to gain an insight as to how it feels and what it is like. This was fed into this document but it doesn't need to stop there, when commissioning a service for any age, this is a prime opportunity for you to reach out and involve your service users and their families.

For me, a promising aspect of this document is how it takes into careful consideration that everyone has a life course, not a stagnated development. It therefore doesn't show the different stages as separate entities but in fact shows the continuous journey between childhood to adulthood with a clear emphasis on the challenging transitional period for those with complex health needs. In your services, it is vital that the transition period isn't forgotten like so many young people cite when they fall in the gap. Both children and adult services therefore hold joint responsibility in making sure that this move is carried out in a person centred manner with respect for the individual's views.

When commissioning rehabilitation, it isn't necessary to reinvent the wheel but what can be done is to look at what's already on that wheel and how those ideas can be shared and reflected in your service. This document highlights where good practice has been made. With this document there is an accessible platform to view all the incredible work that happens across England, enabling you to bounce off of other's ideas and form the best, service user friendly rehabilitation service possible. **Amy Frounks**

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Key messages

REHABILITATION INTERVENTION UNDERPINS ALL CONDITIONS

REHABILITATION IS EVERYONE'S BUSINESS

REHABILITATION INTERVENTION RUNS THROUGH THE LIFE COURSE

The World Health Organisation[1] states that rehabilitation intervention should be aimed at achieving the following broad objectives:

- preventing the loss of function
- slowing the rate of loss of function
- improving or restoring function
- compensating for lost function
- maintaining current function

The NHS England Improving Rehabilitation Programme applies these principles in a holistic way to encompass both mental and physical health.

Overview of the document

This document has seven main sections. Readers can jump into sections; move easily within and between sections, and access appendices, pdf documents and web-based resources.

SECTION 1 WHAT IS REHABILITATION?
Provides a working definition of rehabilitation and describes the breadth and depth of what rehabilitation means.

SECTION 2 REHABILITATION MODEL
Shows a model representing the complexity of the range and scope of rehabilitation.

SECTION 3 PRINCIPLES AND EXPECTATIONS
Explains what good rehabilitation means to service users and their families and carers.

SECTION 4 WHY COMMISSION REHABILITATION?
Demonstrates the value of commissioning rehabilitation for service users, the health and care system and society.

SECTION 5 CHECKLIST AND TEN TOP TIPS
Presents a useful checklist and tips to consider when commissioning rehabilitation.

SECTION 6 BENCHMARKING TOOL
Presents a benchmarking tool and expands on the principles and expectations underpinned by evidence.

SECTION 7 WHO PRODUCED THIS GUIDANCE? GLOSSARY AND DEFINITIONS; REFERENCE LIST AND BIBLIOGRAPHY
Lists the authors and stakeholder group members, together with people who have kindly given their time to review and comment on this guidance during its development.

Contains a glossary and definitions, and a comprehensive reference list with web links to full text documents and appendices. This supports the content of the guidance and provides an additional useful resource.

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WHAT IS REHABILITATION?

The definition of rehabilitation

A modern healthcare system must do more than just stop people dying. It needs to equip them to live their lives, fulfil their maximum potential and optimise their contribution to family life, their community and society as a whole.

Rehabilitation achieves this by focusing on the impact that the health condition, developmental difficulty or disability has on the person's life, rather than focusing just on their diagnosis. It involves working in partnership with the person and those important to them so that they can maximise their potential and independence, and have choice and control over their own lives. It is a philosophy of care that helps to ensure people are included in their communities, employment and education rather than being isolated from the mainstream and pushed through a system with ever-dwindling hopes of leading a fulfilling life.

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

'REHABILITATION IS NOW CENTRAL TO THE WAY THAT WE DELIVER OUR HEALTH SERVICES...'

Sir Bruce Keogh *– NHS England Conference – "Rehabilitation = Living my life" 31 March 2015, Bloomsbury*

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The range and scope of rehabilitation

Rehabilitation covers an enormous spectrum within our patients' pathways. It includes support to learn basic communication skills; exercise classes to improve or maintain optimum health, wellbeing and occupation; and complex neurological rehabilitation following major trauma or stroke. Rehabilitation may be appropriate at any age as a person's needs change through the course of their life. For example, they may require support to:

- **develop skills for the first time –** children may require help to develop skills (habilitation) in order to overcome barriers presented by a range of developmental difficulties and health conditions to achieve maximum health and independence in adulthood[2, 3, 4, 5]
- **recover from unexpected illness –** such as depression, anxiety, psychosis, acute admission to hospital following a stroke, surgery, a fall, chest infections and cardiac events[6, 7, 8, 9]
- **manage long-term conditions –** when people with a long-term medical or neurological conditions become unexpectedly ill or have an exacerbation, they benefit from rehabilitation intervention to help them regain or maximise their independence[6, 7]
- **self-manage conditions –** people with a long-term condition are enabled to manage their own health and reduce the risk of developing secondary problems affecting either their mental or physical health, such as loss of strength and cardiovascular fitness, contractures, pressure ulcers, pain, anxiety and depression[6, 10, 11]
- **recover from major trauma –** rehabilitation and reablement help people to regain and maximise their skills and independence, including returning to work (vocational rehabilitation)[12]
- **maintain skills and independence –** for progressive conditions (such as dementia, motor neurone disease and terminal cancer), early diagnosis, assessment and rehabilitation intervention can help people to maintain their skills and independence for as long as possible[6, 13, 14]
- **access advocacy –** people who are vulnerable and need support (such as those with cognitive impairment or communication difficulties) are offered advocacy as part of their rehabilitation package

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Rehabilitation intervention is provided in the primary care setting, in the acute hospital setting (during an inpatient episode or as an outpatient referral) or in the community. The breadth of rehabilitation means that a range of organisations may contribute to meeting a person's individual needs, including the NHS, local authorities, user-led and community groups, and independent and charitable organisations.

Rehabilitation intervention is essential in helping to address the impact of:

- **physical or movement problems –** such as impaired motor control; loss of limbs; reduced balance, strength or cardiovascular fitness; fatigue, pain or stiffness
- **sensory problems –** such as impairment of vision or hearing; pain; loss of or altered sensation of touch or movement
- **cognitive or behavioural problems –** such as lapses in memory and attention; difficulties in organisation, planning and problem-solving
- **communication problems –** such as difficulties in speaking, using language to communicate and fully understanding what is said or written
- **psychosocial and emotional problems –** such as the effects on the individual, carer and family of living with a long-term condition. These can include stress, depression, loss of self-image and cognitive and behavioural issues
- **medically unexplained** symptoms **–** where a holistic approach is needed to ensure the best possible support for both mental and physical wellbeing
- **mental health conditions –** such as anxiety and depression, obsessive/compulsive disorders, schizophrenia, eating disorders, post-traumatic stress disorder and dementia

Rehabilitation as prevention or early intervention

Although it is often attributed to the end of a treatment pathway, rehabilitation intervention can have significant impact as a preventative measure.[15] For example:

- exercise post-stroke has been shown to reduce the risk of further vascular event[16]
- advice and support directed towards smoking cessation, physical activity, obesity management, and maternal and child nutrition reduces the risk of adult cardiovascular disease[17] (F,J)
- it is well established that rehabilitation intervention reduces the risk of coronary heart disease and then reduces the risk of further events[8]

If accessed at an earlier stage in the pathway, prehabilitation intervention (such as prior to surgery) can improve functional outcomes, reduce length of hospital stay and enable timely return to work or occupation.[18]

Both prevention and prehabilitation are powerful tools for achieving a good outcome for individuals. They also reduce health inequalities, the cost of healthcare and give an increased return on investment in rehabilitation.

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Click here for definitions of terms

Rehabilitation | Habilitation | Reablement | Prevention | Secondary prevention

A person-centred approach

A person-centred approach is fundamental to ensure that rehabilitation is as an active and enabling process for each individual. It ensures that support is built around a person's own circumstances and responds to the diversity of needs that will be present. This includes consideration of mental and physical health, and the relationship between these which is critical to planning effective care.[224, 225]

There is strong evidence that people see this as vital, as highlighted during NHS England's stakeholder engagement project to determine "what good looks like" from the individual's perspective. This led to the development of the document *Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation.*[26]

A person-centred approach is also a core element of the document *Special Educational Needs and Disability: Code of Practice 0-25 Years*, which is statutory guidance for organisations working with children and young people.[5]

Working in this way ensures that people have access to the professional support, advice and intervention they need in order to achieve their personal rehabilitation goals, maximise their independence and exercise control over their lives.

A person-centred approach within rehabilitation is key to achieving the vision for future healthcare as set out in the *Five Year Forward View*.[19]

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Rehabilitation supports the following aspects of a person-centred approach:

Self-management

The participatory nature of rehabilitation helps people to take real control of their condition. This can include understanding:

- how to monitor themselves
- what measures to take to prevent a recurrence or deterioration
- how to avoid secondary problems or, in the case of progressive conditions, how to maintain levels of health and function for as long as possible

People are signposted to websites and community resources that can support them and are given quick and easy access back into rehabilitation services if they need further specialist input. This includes the ability to re-refer themselves (E, J, K, L).

For people with high levels of dependency on others (for example, young children or adults with severe cognitive impairments), self-management may be achieved through close working with families, carers and advocates (SS).

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.

For children and young people, funding for health, social care and educational support can be used to support delivery of one 'single plan'. For examples of how this can make a real difference, click here.

By 2020 the goal within the government's mandate to NHS England[31] is that the number of people with a personal health budget should increase from an estimated 4,000 to 50,000-100,000. Thus an opportunity should be made for people to access this choice.

Integrated personal commissioning

This gives individuals the control to integrate their own health and social care budgets. For more information, click here.

Co-production of care plans

A key project within the work of NHS England's long-term conditions team, this approach aims to empower patients and help them to manage their own long-term health conditions as efficiently and effectively as possible.

Individuals should be involved during service design: "Co-production is built on the principle that the people who use a service are best placed to help design and improve it." For more information, click here.

High-quality rehabilitation has co-production of care plans at its centre, with individuals setting their own goals in partnership with their rehabilitation professionals.

Capacity and activation

Understanding people's ability to make informed decisions and choices about their health and rehabilitation requirements enables the multi-agency team to provide the most useful and efficient support. Monitoring mental capacity (and assessing where appropriate) is fundamental to maximising an individual's ability to make informed choices and exert control over their own lives, while also ensuring their safety.

The individual's level of activation in managing their own health also needs to be considered. Hibbard et al[21, 22, 23] and The King's Fund describe the patient activation model and patient activation measure, which can determine the individual's ability and motivation to change. This may vary according to age, education level, health literacy, motivation and illness and has been shown

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to be a strong predictor of healthy behaviour. An individual's activation levels can be increased through targeted interventions that develop skills in achievable steps and build confidence and autonomy. Rehabilitation services deliver interventions with these key elements.

The following examples show how capacity and activation levels can affect access to healthcare:

- a young person with a learning disability may have limited capacity but be able to exercise more choice, control and independence in managing their own health if their activation levels increase
- an adult with a long-term physical or mental health condition may have full capacity and a high activation level, giving them complete independence in their life choices, with minimal rehabilitation advice and signposting required
- an adult with multiple sclerosis may have a temporary reduction in both their capacity and activation levels during a hospital admission for aspiration pneumonia, but may recover both during a course of medication and rehabilitation intervention

A person-centred approach therefore means identifying the type of support and reasonable adjustments that enable each person's needs to be met.

The range of rehabilitation specialists

While everyone who comes into contact with service users during their care has a role to play in their rehabilitation, some healthcare professionals have specialist knowledge and skills within the rehabilitation process. They can provide specialist assessment, advice and support for individuals and their families, and guide the work of the multi-agency, care and social support teams. Click on the buttons for more information.

- Art therapist
- Audiologist
- Clinical nurse specialist
- Clinical psychologist
- Dietitian
- Doctor of rehabilitation medicine
- Dramatherapist
- Music therapist
- Occupational health professional
- Occupational therapist
- Orthoptist
- Orthotist/Prosthetist
- Physiotherapist
- Podiatrist/ Chiropodist
- Psychiatrist
- Radiographer
- Specialist social worker
- Speech and language therapist

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Partnerships supporting person-centred rehabilitation

Effective partnerships across teams, voluntary agencies, community resources and independent-sector resources are central to providing the right support in the right place for each individual.

Working with local authorities is key to ensuring good outcomes for people throughout their life course. For example:

- children and young people with special educational or developmental needs and disabilities may require habilitative support to achieve their full learning potential (QQ)
- frail elderly people may require social care and rehabilitation to stay living in their own homes (H, N, DD)
- ensuring that people using mental health services can access these as close to home as possible, reducing the need for 'out of area' provision[222]

Effective partnership working between voluntary and community organisations (such as housing associations) can make a real difference to people's lives (F, W).

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REHABILITATION MODEL

Effective rehabilitation takes a holistic and individualised approach. This is because two people with the same diagnosis may have very different abilities and needs because of a complex interaction between their health conditions, the environments they live in, their values and beliefs, and their aspirations and motivations. The interaction between an individual's mental and physical health is also key, with one having the potential to significantly affect the other.[224, 226]

A "biopsychosocial model" has been developed by the World Health Organisation[24] to capture the complexity of this approach. The *International Classification of Functioning Disability and Health* (WHO ICF) provides a way of describing and classifying the continuum of human functioning. It should be applied to the clinical approach as a framework for analysing and classifying needs, planning holistic care and monitoring progress and outcomes. For a diagrammatical representation of the WHO ICF, click here.

Kärrholm et al[25] describes multi-professional, coordinated rehabilitation intervention as essential because it gets people back to work sooner and gives them improved physical, social and emotional functioning and wellbeing, resulting in the creation of "healthy time".

The model on the next page has been developed to demonstrate the different stages of the rehabilitation pathway. It is a complex model and should be interpreted flexibly according to the needs of the local population and the rehabilitation pathway of each patient:

- an individual may reach their potential within phase 1, requiring a complex package of care to support them to live their life as independently as possible. This person may require occasional support from a specialist team to enable appropriate long-term management of their condition
- an individual may reach their potential within phase 3. They may require support to manage their condition and health needs; they may need to re-access specialist support at intervals to help them maintain their independence and function throughout their life course
- an individual within phase 3 may have a progressive long-term condition. The complexity of their needs may mean they require ongoing review from a medical specialist with regular intensive bouts of specialist therapy intervention
- depending on their need, an individual may be able to manage without extra support from outside their family circle, but access resources from phases 4, 5 or 6 to maintain their physical and mental health and fitness

Transition between the phases and exiting and re-entering different phases can be critical times for the patient and their families. Good networks and communications between the different teams are therefore essential and need to be dependable and consistent.

It is not possible to include specific guidance on which body funds which section or phase of rehabilitation in this model because it depends on the patient's health condition and their particular needs. However, in general:

- **phase 1** will be mostly funded through national commissioning (NHS England)
- **phase 2** is likely to be either nationally or locally funded (NHS England or CCG's and local Authorities)
- **phase 3** is most likely to be locally funded
- **phase 4** could be locally or privately funded (by the individual)
- **phases 5 and 6** could be privately, voluntary or charitably funded (grants for charities, voluntary groups and services that the public sector does not fund)

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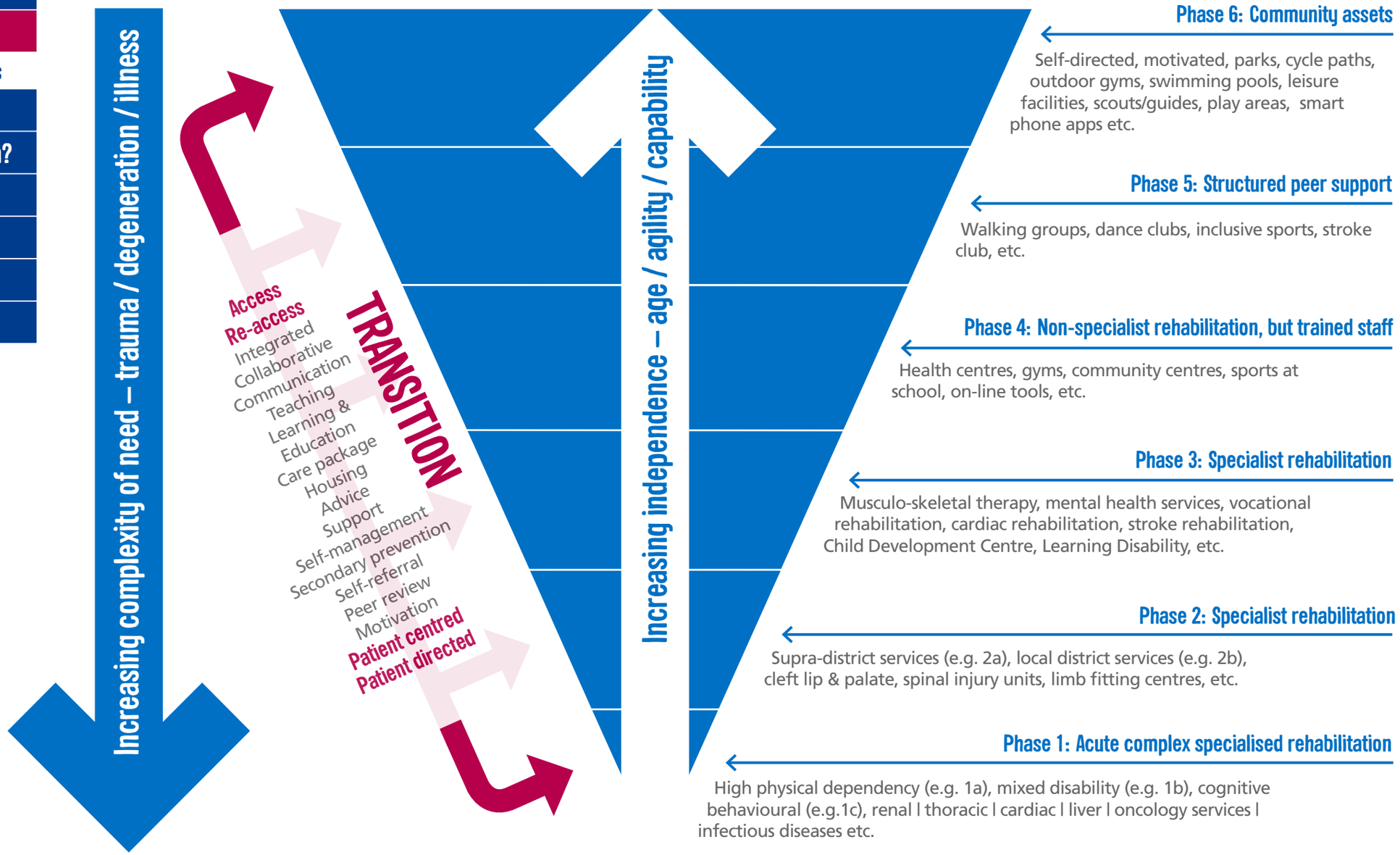
The Model of Rehabilitation Services



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PRINCIPLES AND EXPECTATIONS

The document *Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation*[26] was developed inductively by the NHS England *Improving Rehabilitation Services* programme. It used consensus group methods with a variety of stakeholders including patients, healthcare professionals, commissioners, strategic clinical networks and NHS England national clinical directors. There was strong consensus that the system needed to change and about key specific principles that should underpin rehabilitation practice.

The document describes what good rehabilitation looks like and offers a national consensus on what patients and their carers should expect.

The principles and expectations have been developed to describe the components of good services. The expectations are "I statements" to indicate the importance of partnership working – both with other agencies and, most importantly, with the individual.

The principles and expectations are presented below. However, since the document was published, work has progressed within the team to underpin the results deductively with evidence derived from key national documents, guidelines and research. The resulting resource can be found under the "Benchmarking tool tab".

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The expectations of good rehabilitation services

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

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The principles of good rehabilitation services

Good rehabilitation services will:

1. Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs
2. Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team
3. Instil hope, support ambition and balance risk to maximise outcome and independence
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
5. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential
7. Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy
8. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week
9. Have strong leadership and accountability at all levels – with effective communication
10. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research

These expectations and principles reflect the aims of a future health and care system,[19, 20] are drawn directly from the comments of service users and are underpinned by peer-reviewed evidence.

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WHY COMMISSION REHABILITATION?

The needs of an ageing and diverse population, the changing burden of disease, and rising patient and public expectations mean that innovative ways of providing effective and efficient high-quality rehabilitation outcomes must be found.

People must be empowered to take control of their own lives, manage their conditions and draw on community assets as well as NHS services to make this happen.

There needs to be a focus on preventing illness and injury and on the prevention and management of secondary problems arising from existing health conditions[19].

Rehabilitation intervention can help to achieve these ambitions, in particular:

- prevention and reduction in demand for health services
- support for people to stay in or get back to employment
- support for people to gain greater control of and self-manage their care
- integration of out-of-hospital care wherever possible, so that length of stay and unplanned admissions can be reduced
- breaking down of traditional barriers, such as services for mental and physical health, ensuring a holistic approach

There is compelling evidence that rehabilitation services can deliver long-term cost reductions and add value and equality across the health and care system.[27]

For further details of the economic benefits as well as good practice examples, access the drop down menus below using the open and close buttons.

- Support to ensure children and young people with health and developmental conditions have the best start in life
- More control for patients and the ability to self-manage
- Reduction in the demand for primary and secondary care
- Prevention of hospital admissions (and readmissions) and visits to A&E
- Reduction in the length of hospital stays
- Help for people with long-term conditions to enable a better quality of life
- Support for people to enter and stay in employment
- Improved health outcomes from surgery (particularly elective) and other interventions

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NHS, public health and social care outcome domains

An overwhelmingly large number of outcomes are positively influenced by rehabilitation intervention. Using this guidance will contribute to the improvements outlined in the three outcomes frameworks published by the Department of Health.[28, 29, 30]

Rehabilitation for specific patient conditions and care groups

For commissioning for rehabilitation within specific conditions or care pathways, click on the tabs below. Here you can view specific national service frameworks, clinical guidelines, key research documents and some prevalence data related to the condition within the UK population.

- Acquired brain injury
- Amputees
- Armed forces
- Cancer
- Cardiac
- Cerebral palsy
- Cystic fibrosis
- Dementia
- Diabetes
- Elderly and frail elderly
- Falls
- Learning disabilities
- Long-term conditions
- Major trauma
- Mental health
- Musculoskeletal
- Neurological
- Obesity
- Pain
- Palliation
- Pulmonary
- Spinal cord injury
- Stroke
- Transsexual, transgender, & gender- nonconforming people
- Vocational
- Other relevant documents

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Commissioning for outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. *The Government's Mandate to NHS England for 2016-17*[31] has an expectation that improvements will be demonstrated against the *NHS Outcomes Framework*[28] so as to provide evidence of progress and enable comparison of services locally. The document *Commissioning for Outcomes: A Narrative from and for Clinical Commissioners* contains guidance.[32]

When considering what outcome data to request from providers, the following should be considered:

- what outcome data is already collected locally (by the team managers and clinicians)?
- what outcome measurement tools are appropriate for the client group, health condition and method of service delivery?
- will it enable benchmarking with other services?
- will it show how existing inequalities have been reduced in terms of access to services, experiences of services and outcomes achieved?[27]
- is occupation (including work and educational achievement) considered as an outcome?

Nationally, two large groups of rehabilitation teams, the UK Rehabilitation Outcomes Collaborative (UKROC)[33] and Sentinel Stroke National Audit Programme (SSNAP)[34], have already established systems to record service level, patient dependency level and individual patient function and ability. This now allows national benchmarking and comparisons of both care and rehabilitation pathways.

The economic benefits of commissioning rehabilitation services

The aim of this section is to demonstrate the economic benefit that results from rehabilitation intervention and to provide evidence that it can save money within the context of health and social care; thus enabling a system wide collaborative open approach to the implementation of Lord Carter's recommendations.

Drummond et al[35] describe the economic evaluation of rehabilitation as: '… the comparative analysis of alternative courses of action in terms of both their costs and their consequences.'

However, it is difficult to pick out both the specific costs of intervention and the variety of consequences and benefits to the patient, their family, their carers and the health and social care system3[6].

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In partnership with the World Health Organisation[1], Howard-Wilsher et al[37] carried out a systematic overview of economic evaluations of health-related rehabilitation, the results of which demonstrate that:

'... COST-EFFECTIVENESS EVIDENCE SUPPORTS THE VIEW THAT HEALTH-RELATED REHABILITATION SERVICES SHOULD HAVE SIMILAR PRIORITY TO CONVENTIONAL MEDICAL TREATMENTS IN HEALTH CARE SYSTEMS.'

There are several ways that rehabilitation intervention can deliver savings within the context of health and social care. For example, it can:

- enable a person to return to work, get into work or stay in work
- reduce the cost of nursing, residential and social care
- reduce the risk of falls
- reduce the associated costs of mental health illness
- reduce the costs associated with diabetic care
- reduce length-of-stay costs
- realise the potential of children and young people

Return to work, get into work, stay in work

Rehabilitation intervention and support can help an individual return to work after injury or illness or help a young adult with a long-term condition get into work for the first time. It can help a person with a progressive illness or condition stay in work for as long as possible or help parents of children and young people with long-term conditions to get and stay in work. Some examples are:

- Kärrholm et al[25] found that multiprofessional, co-ordinated rehabilitation intervention got people back to work sooner and also improved their physical, social and emotional functioning and wellbeing. The value of creating "healthy time" for people who had been ill was one of their key findings
- York Hospital NHS Foundation Trust provided early rehabilitation intervention for their staff who were ill and on sick leave. They invested £160,000 and found a 40% reduction in long-term sickness, with cost savings of £1.2m per year[38]
- Colchester Hospital University NHS Foundation Trust allowed staff with musculoskeletal disorders early access to rehabilitation. They found that 53% of staff remained in work and 21% of staff returned to work within eight days. Savings of £586,000 were realised over six months[39]
- Radford et al[40] found that specialist vocational rehabilitation intervention enabled more participants to return to work after traumatic brain injury than those in the control group. Patients

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with more complex disabilities found more benefit from the intervention than those with less complex injuries

- If half of breast cancer survivors who initially return to work but then leave were helped to remain in work, the economy could save £30m every year[41]
- Marsh et al[42] found that enhanced speech and language therapy intervention for young people is estimated to result in an additional 5,500 students achieving five or more GCSEs A*-C (or equivalent) in comparison with routine speech and language therapy

Reduce the cost of nursing, residential and social care

Rehabilitation for brain injury has been shown to reduce the need for continuing care and to reduce overall costs[43, 44,] particularly in more dependent patients. Improvements in outcomes from inpatient rehabilitation for patients who are severely disabled offset the average cost of their rehabilitation (£41,488) over a period of 156 days in 16.3 months. While these patients still require long-term care, their dependency is reduced, with an average saving in the weekly cost of care of £243. These savings are calculated for a cohort with an average age of 43.3 years, demonstrating a significant lifetime cost reduction in care.[45]

Adults with autism are more likely to have the skills necessary to live in supported rather than residential accommodation if they receive enhanced speech and language therapy in their preschool years.[42] Nationally, this generates a lifetime cost saving of £7.2m.

Reduce the risk of falls

In 2012 the top three primary diagnoses for admissions for falls were "fracture of femur" (14.9%), "fracture of forearm" (9.1%) and "open wound of head" (8.5%) (http://www.hscic.gov.uk/catalogue/PUB11051). To reduce the risk of falls and of serious injury and admission to hospital after a fall, a falls service was set up within an NHS community learning disabilities team to provide an individualised programme to improve gait and balance. The results showed an improvement in balance and mobility and a decrease in the number of falls.[46]

The Chartered Society of Physiotherapy (CSP) reports that the cost of falls to the NHS is more than £2.3bn each year. Because the population of people aged over 65 is predicted to rise to nearly 50% within the next 20 years, the potential future cost (excluding inflation) could be in the region of £3.4bn. Physiotherapy intervention, either on an individual or group exercise basis, reduces the number of falls and thus the cost to the NHS and society (http://www.csp.org.uk/documents/falls-prevention-economic-model). Within this web link, the CSP also provides a falls prevention economic model which allows commissioners to calculate the potential impact of falls in terms of both patient and financial outcomes.

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Reduce the costs associated with mental health conditions

PRIMARY MENTAL HEALTH CONDITIONS

The economic case for investing in services to meet the needs of people with mental health conditions is set out in *The economic case for improving efficiency and quality in mental health*[125], it provides a comprehensive overview of how mental health services across the life course and across a broad range of mental health conditions can provide value for money to taxpayers.

INTEGRATED CARE FOR MENTAL AND PHYSICAL HEALTH

The link between mental and physical health has been well established.[225, 226] The following studies show the potential to reduce costs by considering physical and mental health at the same time:

- Exercise can have a significant and positive impact on behavioural and psychological symptoms of dementia[47], improving cognitive function and mood, which can reduce the need for pharmacological intervention.[48]
- Physiotherapy services for people with dementia have been identified as key in contributing to a cost saving of £6m a year, including reducing the length of stay.[49]
- Including a psychological component in a breathlessness clinic for chronic obstructive pulmonary disease in Hillingdon Hospital led to fewer A&E presentations and fewer hospital bed days per person in the six months after intervention.[227] This translated into savings of £837 per person – around four times the upfront cost.
- In the year following a cognitive behavioural therapy based disease management programme for angina, patients needed 33% fewer hospital admissions – saving £1,337 per person.[228]

Reduce the costs associated with diabetic care

Physical activity has been shown to improve glycaemic control to levels comparable to pharmaceutical intervention, thus reducing prescribing costs. Diabetic-related complications are reduced by 32% and diabetic-related mortality by 42%.[10]

Taking a holistic approach which includes psychological, social and physical health care has been found to be cost effective. The 'Three dimensions of care for diabetes' project has seen reductions in A&E attendances, hospital admissions, and bed-days for people with multi-morbidity at risk of diabetes related complications. The service cost was £190,000 for 2 boroughs, but saved £225,000 in one year (XX).

Realise the potential of young people

Rehabilitation for children and young people unlocks social, educational and economic potential. It aims to maximise independence in adulthood and reduce additional lifetime costs associated with health needs, provision of social care, the need for additional support in school or financial support via the benefit system.

While more work is needed to fully understand the economic benefits of paediatric rehabilitation, there are a number of studies within different clinical areas where intervention for children and young people has been demonstrated as cost effective:

- there is increasingly good data on the return on investment and future cost savings from prevention and early intervention: for example, a 6-10% annual rate of return on investment for spend on intervention in the early years[50]
- the *Triple P* parenting programme is identified by the National Institute for Health and Care Excellence (NICE) as being cost effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money[4]
- every £1 invested in enhanced speech and language therapy generates £6.43 through increased lifetime earnings. Approximately 203,000 children aged 6-10 years in the UK have speech and language impairment requiring therapy. The estimated annual net benefit is £623.4m in England[42]
- interventions resulting in just a 1% reduction in the number of young people aged 16-17 who are obese or overweight can result in significant cost saving in medical care across the population[51]

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Reduce length-of-stay costs

There are many examples demonstrating that increasing the provision of rehabilitation intervention can reduce the number of days spent in hospital, thus reducing costs and freeing bed space for new admissions:

- an integrated amputee rehabilitation service at Guy's and St Thomas' NHS Foundation Trust (London) reduced length of stay from 40 days to 22 days by giving people with traumatic amputations early access to a prosthetics service[52]
- for people with a "fragility" fracture, early referral to an orthogeriatrician-led multidisciplinary rehabilitation service enabled patients to have a reduced length of stay in hospital (reducing the mean length of stay from 8.3 to 4.6 days). Savings were projected to be £75m if this service were rolled out across the NHS. Another benefit of this intervention would be to improve patient experience[53]
- intervention from the Northern Devon Healthcare Trust stroke therapy team reduced length of stay by 6 days from 22 days, saving £833,700. Hospital readmission rates reduced from 65% to 3% as a result of strengthened links with community nurses and 13% more patients returned home rather than to a care home, saving over £75,500 per person[54]
- in 2003, the first malnutrition universal screening tool (MUST) report[54] stated that malnutrition predisposes to disease, delays recovery from illness and adversely affects body function, wellbeing and clinical outcome. By minimising malnutrition, a 5-day reduction in length of stay is possible, providing an annual saving of £266m
- Bradley et al[18] found that investing in a prehabilitation programme consisting of four sessions of exercise classes, smoking cessation, dietary advice and patient education reduced length of stay, complication rate and readmissions for people undergoing surgery for lung cancer. This gave a cost saving of £244 per patient

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Invest in rehabilitation to save money

It is clear that providing rehabilitation intervention:

'... ENABLES AN INDIVIDUAL TO MAXIMISE THEIR POTENTIAL TO LIVE A FULL AND ACTIVE LIFE WITHIN THEIR FAMILY, SOCIAL NETWORKS, EDUCATION/TRAINING AND THE WORKPLACE WHERE APPROPRIATE.'

It is also clear that rehabilitation intervention has a financial benefit within the health and social care context. Although rehabilitation requires investment, it saves money in the medium-term and long-term. For example:

- for every £1 spent on orthotic services, £4 is saved. This represents a saving of £400m to the NHS[56]
- self-referral to musculoskeletal (MSK) physiotherapy services reduced patient-related costs such as prescribing, X-rays and magnetic resonance imaging. Self-referral saved £25,000 per 100 population[57]
- self-referral to MSK physiotherapy costs 25% less than traditional GP referral and GP-prompted self-referral costs 10% less per episode. Self-referral releases capacity in primary and secondary care[58]
- every £1 invested in low-intensity speech and language therapy for swallowing difficulties is estimated to generate £2.3m in healthcare cost savings through the avoidance of chest infections[42]
- Sandwell and Birmingham NHS Trust established a 7-day community rehabilitation team which resulted in 93% admissions avoidance in terms of referrals of people who would have been taken to hospital. The service receives 10,000 referrals per year[52]
- Derbyshire Community Health Services NHS Foundation Trust (winner of the Rehabilitation Innovation Challenge Prize 2015) provided a *Fitness for Work* programme. Staff were self-referred or referred by their manager and a £48,000 investment produced savings of £250,000 in sickness absence costs[59]

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CHECKLIST AND TEN TOP TIPS

This section provides guidance on considerations when commissioning rehabilitation that will maximise an individual's health and wellbeing across their life course.

Checklist

✓ People-centred services

It is essential that the views and needs of service users are at the heart of commissioning and delivering rehabilitation services. The principles and expectations for good adult rehabilitation describe these needs and will enable local dialogue between commissioners, service users and providers.

Considering the components of good rehabilitation in commissioning decisions will ensure rehabilitation services can meet the expectations of the people they serve[26]

Good rehabilitation

- Focuses on good outcomes that are set by the people we treat and driven by their goals
- Centres on people's needs, not their diagnosis
- Aims high and includes vocational outcomes
- Is an active and enabling process – not passive care
- Relies on interdisciplinary team working
- Responds to changes in people's needs
- Integrates specialist and generalist services
- Requires leadership for transformational change
- Gives hope

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✓ Consider existing guidance and standards

Within this commissioning guidance, specific conditions and care groups have been referenced alongside key national documents and research. Further guidance and resources to support commissioning of rehabilitation services include:

- *Improving the Quality of Orthotics Services in England*[60]
- *Rehabilitation, Reablement, Recovery: Quality Guidance Document*. Wessex Strategic Clinical Networks[61]
- South of Tyne and Wear's Rehabilitation Strategy[52]
- *A Collaborative Approach to Rehabilitation, Reablement, Recovery, Survivorship and Prehab*. South West Strategic Clinical Network. You can find this document here.
- Improving Rehabilitation Services in England: Sharing Best Practice in Acute and Community Care[52]
- *Improving Rehabilitation Services Community of Practice: generating discussion, debate and resources to support improvement in rehabilitation services.* find more resources and information here.
- *Unbundling Recovery: Recovery, Rehabilitation and Reablement National Audit Tool*[174]
- *Long Term Conditions Year of Care Commissioning Programme*, Unbundling Recovery Simulation Model. You can find this document here.
- *In Sight and In Mind. A toolkit to reduce the use of out of area mental health services*[222]

✓ Integrated children and young people's services

The Children and Families Act 2014[62] sets out expectations of how services for children and young people with special educational needs and disabilities (SEND) will be provided. There is a requirement for commissioners and providers from across health, social care and education to work together to provide joined-up services that meet the needs of individuals.[5] There is also a shared responsibility to outline a "local offer" of services for children and young people with SEND, which must be clearly set out for families on a website hosted by each local authority. The local offer must include services commissioned and/or provided by the NHS and gives the opportunity for commissioners to ensure that clear and up-to-date information on their services is available to children, young people and their families.

The legislation emphasises joint commissioning of services to guarantee a person-centred approach and includes ensuring smooth transition from paediatric to adult services. Services must prepare young people and their families and carers for the transfer of their care. As the age of transition may vary, it is important that commissioners consider each individual's requirements to ensure there is no gap in the provision of services. Adult services "'receiving" these young people should be familiar with the needs of a young person with complex long-term conditions. National Institute for Health and Care Excellence guidance on transition to adult services is in development.

An example of guidance for the joint commissioning of services for children and young people with communication needs can be found here. From 2016 provision for children and young people with SEND will be jointly inspected by the Care Quality Commission and Ofsted to ensure that the local authority and local health services are working well together to meet their needs.[63]

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✓ Commissioning for the whole pathway

The model for rehabilitation demonstrates the potential pathways across all rehabilitation services, including those that support maintenance of health and wellbeing. Some people will follow the entire pathway and some will only need access to certain parts. Services must be commissioned to ensure smooth transition across all elements of the patient's pathway; this should include re-access or entry to services a person may previously have been discharged from. Good communication between services along each individual's pathway is essential for them to achieve the best possible outcome.

Consideration should be given to the provision of specialist and core rehabilitation services across acute and community settings to ensure people can access the right service in the right place for them. Furthermore, integration with voluntary and third-sector partners can support people and their families to live as independently as possible and create access to additional services. For example, peer support groups and social events can reduce social isolation and increase self-confidence for all.

To hear a local commissioner describe how rehabilitation can deliver on local priorities, and the considerations in commissioning these services, click here.

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Ten top tips for commissioning local rehabilitation services

1. Recognise the rehabilitation you already commission:

- does your clinical commissioning group (CCG) have a listing of all providers and their rehabilitation services?
- rehabilitation is essential in order to meet the requirements of domains 2 and 3 of the NHS Outcomes Framework 2015/16
- do you know who commissions level 1 and 2 rehabilitation in your area (NHS England and surrounding CCGs)?

2. Have ambition for your services and the people they serve:

- consider encouraging services to start small and then support them to grow

3. Make your services "join up" and have some common key principles in your service specifications:

- does walking the pathway of care with a user identify any gaps or areas for improvement?
- do you join up with other CCGs? Do you share risk for less common needs and presentations? For example, brain injury rehabilitation is often most effective for populations of 6-700,000
- are there established communication channels between services, including between mental and physical health service providers?

4. Rehabilitation should not be "extra" or an "add-on" – it should be considered throughout each person's journey:

- rehabilitation should be part of almost all pathway commissioning
- have you considered how to meet both physical and mental health needs within rehabilitation services?,
- have you considered rehabilitation as integral to your sustainability and transformation plans?

5. Consider what outcomes you want; identify some common measures and ask your services to work together:

- establish what outcome measures are already being collected. Are they robust and can they be used for benchmarking?
- what processes are in place to collect information on patient experience? How is this used by providers to improve service provision?

6. Consider the range of settings where your services are delivered, especially community settings, the third sector and care homes (including respite care):

- have you commissioned services that focus on care closer to home?
- do your service specifications cover rehabilitation in care homes? This is particularly important for prevention of admissions and maintenance of long-term conditions? What are the governance arrangements?

7. Take a strategic view so that you invest to save.

- Have you considered how rehabilitation can help you deliver primary and secondary prevention and early intervention for your local diverse population?
- Have you completed a joint strategic needs assessment for rehabilitation services identifying current inequalities in access and outcomes and future potential demand?
- which services will deliver this across a life course and for particular care groups and types of condition?
- would commissioning self-referral reduce pressure and costs in primary care services?

8. Cross- check your local services against the rehabilitation model to identify gaps or duplication and outcomes being achieved.

9. Ask for advice and support if necessary:

- what forums do you use to share good practice locally, regionally and nationally?

10. Ask your providers and service users how improvements could be made and what can be done differently to improve outcomes for people:

- do you ensure dialogue for improvement and innovation between your providers and service users?

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BENCHMARKING TOOL

The Francis report[64] recommended that commissioning bodies have a requirement and responsibility to monitor and scrutinise services they commission on behalf of their patients. This is possible via their own audit and inspection of services or via the inspection of evidence generated by the provider.

There are excellent examples of adult rehabilitation services throughout England. However, clinicians and patients report that in many areas their needs are not being met. This must change.

The service information and benchmarking tool and the principles and expectations have been developed to support the reduction of variation in access to and quality of rehabilitation services. These are guidance that can be used by commissioning bodies to:

- understand the level of services available to the local population
- appreciate whether the services are meeting the expectations of patients, their families and carers
- scrutinise the quality of the services
- compare rehabilitation services both locally and nationally

They can be used collaboratively with provider bodies, enabling local delivery and reportage of high-quality, transagency and patient-focused rehabilitation services and can be used to understand where gaps exist in the service and to prioritise areas for service improvement.

Rehabilitation service information and benchmarking tool

This model's information can be populated from operational multidisciplinary team level or therapy-specific team level, but is not intended for specialised services because these types of provision are directly commissioned by NHS England. For more information, click here. It can be completed by the provider or potential provider of the service and much of the data is already available, for example:

- within the NHS commissioning board datasets[65]
- within the NHS[28], adult social care[29] and public health outcomes frameworks[30]
- within audit information collected for the *National Audit of Intermediate Care*[66, 67]
- within NHS benchmarking data.

It should be noted that elements of rehabilitation services may be commissioned separately by the local authority or schools, for example:

- assessments for and provision of specialist equipment
- assessments for environmental adaptations including those funded by the Disabled Facilities Grant
- aspects of children's therapy services
- aspects of mental health services

Planning jointly with other local commissioners will ensure a co-ordinated provision for service users and is a requirement in relation to children and young people with special educational needs and disabilities (SEND).[5]

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The service information and benchmarking tool

Focus	Question	Notes
1. What is the service?	Team name/title	
	Team leader	
	Describe the service	*Free text – short description*
	Is there a service specification?	*Yes/No*
	Is there a patient pathway?	*Yes/No*
	Define the services provided in the following categories	*Patient-facing, patient-related non-patient facing, additional operational activities (for example, meetings, admin, training) inreach/outreach, other*
2. Where and when is the service provided and by whom?	Where is the site for provision of the service?	*For example: clinic, school, patient's home, day centre*
	How often is this service provided?	*For example: 1 day per week, 5 days per week, 7 days per week, monthly, bi-monthly, fortnightly*
	When is this service provided?	*Normal day, extended day, evenings, night, 24 hours, on-call*
	Which staff group provides support in the delivery of this service?	*Professions, numbers, skill mix*
3. How many people does the service serve?	What is the average annual number of referrals each year?	*Number*
	How is this information captured?	*Patient Administration Systems, local electronic, local paper based, unknown*
	What is the average wait time?	
	What are the referral criteria for the service?	
	Who are the referrers?	
	What are the pathway expectations?	*Average number of contacts per patient, average length of stay and so on*
	What are the discharge criteria for the service?	
4. Quality information and demonstration of effectiveness	What quality indicators, outcomes or outcome measures are collected?	*For example: audit, patient-reported outcomes, patient-reported experience, intervention-specific outcomes, key performance indicators (Foot et al[68])*
5. Have patients and the public been involved in developing and auditing the service?		*Yes/No*

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Ten principles of good rehabilitation intervention – underpinned by key national documents and research

The document *Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation*[26] was developed inductively by the rehabilitation team within NHS England utilising consensus group methods with:

- individuals and their carers (with a range of medical conditions and differing rehabilitation needs and experiences)
- clinicians regarded as experts (representing a range of allied health professions, medical, nursing and specialities within the professions)
- therapy clinical managers (representing both acute and community settings)
- allied health professional national bodies

The resulting data were analysed and the emergent themes provided the basis for both the "principles" and "expectations". The subsequent piece of work presents a set of principles and expectations that describe what good practice looks and feels like from the perspective of individuals, their carers, therapists, service providers and commissioners. The principles and expectations are deliberately ambitious and challenging.

These principles and expectations have now been mapped against national strategic documents and are intended to be applied across the full spectrum and life course of physical and mental health rehabilitation services.

These ten principles can be applied to:

- any rehabilitation service that a patient uses
- one or multiple episodes of care or intervention

Well-organised and smooth transitions between services or levels of care are important, and are dependent on the potentially changing, individual rehabilitation needs of the patient.

'EVEN THOUGH THE SERVICES AREN'T THE SAME, THE LEVEL OF COORDINATION IS.'

My Life, My Support, My Choice, National Voices (69)

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The ten principles of good rehabilitation intervention

Principle	Evidence base	Examples of good practice
Principle 1 **Optimise physical, mental and social wellbeing, and maximise outcome, independence and quality of life for both the patients and their carers or parents.**	Click to see the evidence base	Making carers welcome in mental health (A) Physical health overhaul for patients with mental illness (B) Grove Avenue (C) Delirium recovery programme (H) Health coaching initiative (J) Most innovative student-driven digital tool (K) HIP QIP – Hip fracture quality improvement programme (U) Islington reablement service (X) Snowden@Home early supported discharge team (Z) Identifying the Economic Value of the Keiro Service Pathway[206] (OO)
Principle 2 **Promote collaborative partnership working between all stakeholders, including the voluntary and community sectors, directed by the patient, their carers and relatives as appropriate (including the provision of equipment and accommodation).**	Click to see the evidence base	Grove Avenue (C) Principia Partners in Health (D) Adult ability team (E) Waistlines (F) Nottingham Recovery College (M) Early intervention team (P) Westminster Integrated Gangs Unit (Q) Integrated community services team (S) Portsmouth support at home service (BB)
Principle 3 **Use an individualised, person-centred goal-setting approach, empowering the patient and/or their carers to take informed control over their rehabilitation (including vocational rehabilitation).**	Click to see the evidence base	Integrated respiratory services: Hospitals without walls (G) Delirium Recovery Programme (H) Occupational Health Physiotherapy Fitness for Work (I) Health coaching initiative (J) Most innovative student-driven digital tool (K) Cumbria DESMOND diabetes programme (L) Transition therapy team (Y) FAST (EE) Leicester Open Mind in partnership with Fit for Work (FF)

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Principle	Evidence base	Examples of good practice
Principle 4 **Support and enable self-management and secondary prevention through education and information, including appropriate self-re-referral.**	Click to see the evidence base	Adult ability team (E) Health coaching initiative (J) Most innovative student-driven digital tool (K) Cumbria DESMOND diabetes programme (L) Nottingham Recovery College (M) Health coaching (O) FAST (EE) My Health Tools (GG) Big White Wall (LL) COPD checklist project (NN) Identifying the Economic Value of the Keiro Service Pathway[206] (OO)
Principle 5 **Deliver early and ongoing assessment and review; identify rehabilitation needs; provide appropriate therapeutic interventions to enable improved outcomes and seamless transitions.**	Click to see the evidence base	Round-the-clock healthcare (N) Westminster Integrated Gangs Unit (Q) Portsmouth Information, Advice and Support Service (W) Islington Reablement Service (X) Transition therapy team (Y) Hospital assessment and discharge team (AA)
Principle 6 **Have an appropriately educated and trained team, able to utilise a range of interventions and skills that are underpinned by a sound evidence base.**	Click to see the evidence base	Health coaching (O) CQC[70] "Their staff must be given the support, training and supervision they need to help them do their job" Health and Care Professions Council (HCPC)[71]: Continuing Professional Development audit report (II) General Medical Council (GMC)[72] Continuing professional development: Guidance for all doctors (JJ) Royal College of Nursing (RCN)[73] RCN Factsheet: Continuing Professional Development (CPD) for Nurses Working in the United Kingdom (KK)

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Principle	Evidence base	Examples of good practice
Principle 7 **Deliver a needs-led, cost-effective and efficient rehabilitation service using integrated, multi-agency pathways and 7-day services. Communication with and about patients is clear, sensitive, respectful and robust.**	Click to see the evidence base	Integrated respiratory services: Hospitals without walls (G) Early intervention team (P) Westminster Integrated Gangs Unit (Q) HIP QIP – Hip fracture quality improvement programme (U) Snowden@Home early supported discharge team (Z) ICARES (integrated care service) (PP) Accessible Information Standard
Principle 8 **Have strong leadership and accountability at all levels – with effective communication.**	Click to see the evidence base	Building our leaders of the future (R) Integrated community services team (S)
Principle 9 **Share good practice (locally, regionally, nationally and internationally), collect data and contribute to the evidence base by undertaking scientifically valid research, evaluation and audit.**	Click to see the evidence base	Most innovative student-driven digital tool (K) Is there a pathway to recovery through care coordination? (T) Identifying the Economic Value of the Keiro Service Pathway[206] (OO)
Principle 10 **Have robust systems of measurement and monitoring that are standardised, consistent and comparable, enabling local, regional and national interpretation and comparison. Examples are:** • clinical outcomes • suitability and competence • culture • evidence-based tools • staff numbers and skill mix • participation in national audit • patient and public feedback • reduction of inequalities • safety and quality standard with a way of measuring compliance • understanding the impact of intervention (clinical outcome measures, patient-reported outcome measures, waiting times, patient-focused/centred)	Click to see the evidence base	HIP QIP – Hip fracture quality improvement programme (U) SSNAP[74, 75] NHS outcomes framework[28] UKROC national database (level 1 and 2)[33]

Click here to see a quick reference guide for these ten principles, mapped to key national documents and research

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Expectations of good practice in adult rehabilitation services underpinned by key national documents and research

These expectations of good rehabilitation services are taken from the Rehabilitation is Everyone's Business document[26]. A significant number of national documents underpin these expectations.

Would your patients agree with these statements?

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

These reflect the "I" statements in:

- *The Adult Social Care Outcomes Framework 2015/16*[29]
- *Patient Experience in Adult NHS Services*[76]
- *National Audit for Intermediate Care: Patient Reported Experiences*[77]
- *National Audit of Intermediate Care. Summary Report.*[66]
- *National Audit of Intermediate Care. Provider Report.*[67]
- *The Narrative for Person Centred Coordinated Care*[78]
- *Integrated Care: What do Patients, Service Users and Carers Want?*[79]
- *Principles of Integrated Care*[80]
- *My Life, My Support, My Choice: A Narrative for Person Centred Coordinated Care and Support for Children and Young People with Complex Lives*[69]
- *I'm Still Me: A Narrative for Coordinated Support for Older People*[81]
- *Person Centred Care 2020*[82]
- *No Assumptions: A Narrative for Personalised, Coordinated Care and Support in Mental Health*[83]
- *Personalised Health and Care 2020*[84]

WHO PRODUCED THIS GUIDANCE?

The team

This guidance has been developed by the NHS England *Improving Rehabilitation Services* programme team with support and advice from members of both the programme board and the commissioning guidance working group and internal stakeholders.

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Glossary and definitions

A&E	accident and emergency
AHP	allied health professional
BSRM	British Society of Rehabilitation Medicine
CCG	clinical commissioning group
CF	cystic fibrosis
CP	cerebral palsy
COPD	chronic obstructive pulmonary disease
CPD	continuing professional development
CQC	Care Quality Commission
CSP	Chartered Society of Physiotherapy
DESMOND	diabetes education and self-management for ongoing and newly diagnosed
DH	Department of Health
DRG	diagnosis-related group
ECAT	Every Child a Talker
FAST	Fast Assessment Start Treatment
Habilitation	The process of assisting an individual with achieving developmental skills when impairments have caused a delay or blocking of initial acquisition of these skills. Habilitation can include cognitive, emotional/social, fine motor, gross motor or other skills that contribute to mobility, communication, socialisation, performance of activities of daily living and quality of life (adapted from http://medical-dictionary.thefreedictionary.com/habilitation)
HCPC	Health and Care Professions Council
HIP QIP	Hip Fracture Quality Improvement Programme
KHP	King's Health Partners
LTC	long-term condition
Medically unexplained symptoms	persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology http://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance_A4_4pp_6.pdf
MSK	musculoskeletal
MUST	malnutrition universal screening tool
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NIHR	National Institute for Health Research
NSF	National Service Framework
PD	Parkinson's disease
Prevention	Taking action to reduce the incidence of disease and health problems either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/primary-prevention
RCN	Royal College of Nursing
Reablement	Reablement is the active process of an individual regaining the skills, confidence and independence to enable them to do the things for themselves, rather than having things done for them.[61]
Recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness[61]
Rehabilitation	Rehabilitation is a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace where appropriate. Rehabilitation can take place at any time across a life course or in a continuum and may include habilitation, reablement and recovery.

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Secondary prevention	A systematic approach to detecting the early signs of disease and intervening before full symptoms develop http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/secondary-prevention
SEND	special educational needs and disability
SSNAP	Sentinel Stroke National Audit Programme
TEMPO	Trauma East Manual of Operations and Procedures
UKROC	UK Rehabilitation Outcomes Collaborative
WHO ICF	World Health Organization, International Classification of Functioning, Disability and Health

Reference list and web links (where available)

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Equalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

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APPENDIX 1: FIVE YEAR FORWARD VIEW DIAGRAM

Five Year Forward View		Principles of good rehabilitation practice
Sustained action required to address **demand**	Radical upgrade needed in prevention and public health	Make use of a wide variety of new and established interventions to improve outcomes. E.g. exercise, technology, cognitive behavioural therapy
	Support people to get and stay in employment	Instil hope, support ambition and balance risk to minimise outcome and independence Use an individualised, goal based approach, informed by evidence and best practice which focuses on people's role in society.
	Patients gaining greater control of their care supporting self-management and self-care	Support self-management through education and information to maintain health and wellbeing to achieve maximum potential.
Sustained action required to address **efficiency**	Breaking down traditional barriers – GPs | hospitals | physical / mental health | health / social care.	Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs.
	Integrated out of hospital care: single point of contact | case management | risk stratification etc.	Recognise people and those that are important to them, including carers, as a critical part of the interdisciplinary team. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week. Require early and on-going assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition.

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APPENDIX 2: RANGE OF REHABILITATION HEALTH PROFESSIONALS

Rehabilitation professional	Role	Further information
Audiologist	Depending on their specific qualifications and training, audiologists assess, diagnose and manage hearing impairment and balance problems, including the provision of hearing aids.	British Association of Hearing Aid Audiologists http://www.bshaa.com British Academy of Audiology http://www.baaudiology.org
Art therapist	Art therapists provide a psychotherapeutic intervention that enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.	British Association of Art Therapists http://baat.org
Dietitian	Dietitians translate the science of nutrition into practical information about food. They work with people to promote nutritional wellbeing, prevent food-related problems and treat disease.	The British Dietetic Association http://www.bda.uk.com/
Doctor of rehabilitation medicine	Doctors of rehabilitation medicine work closely with many other medical specialties and healthcare professionals to support individuals with complex disabling conditions. They take a holistic approach in order to improve patients' function and promote their participation in society along their whole healthcare pathway.	British Society of Rehabilitation Medicine www.bsrm.org.uk
Dramatherapist	Dramatherapists encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.	British Association of Dramatherapists http://www.badth.org.uk
Music therapist	Music therapists facilitate interaction and development of insight into clients' behaviour and emotional difficulties through music.	British Association for Music Therapy http://www.bamt.org

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Rehabilitation professional	Role	Further information
Specialist nurses	These are nurses specialising in a particular condition or care group such as Parkinson's disease, cystic fibrosis, diabetes and stroke. They often work independently within a multidisciplinary team with responsibility for planning, advising, assessing, delivering specific interventions, offering follow-ups, prescribing and referring on for further investigations or to another professional. Community psychiatric nurses specialise in working in community settings with people who need mental health services.	Royal College of Nursing http://www.rcn.org.uk
Occupational therapist	Occupational therapists assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function.	British Association of Occupational Therapists and College of Occupational Therapists http://www.cot.co.uk
Orthoptist	Orthoptists diagnose and treat eye movement disorders and defects of binocular vision.	British and Irish Orthoptic Society http://www.orthoptics.org.uk
Physiotherapist	Physiotherapists assess and treat people with physical problems caused by accident, ageing, disease or disability, using physical approaches in the alleviation of all aspects of the person's condition.	Chartered Society of Physiotherapy http://www.csp.org.uk
Podiatrist/ Chiropodist	Chiropodists/Podiatrists diagnose and treat abnormalities of the foot. They give professional advice on prevention of foot problems and on proper care of the foot.	Society of Chiropodists and Podiatrists http://www.feetforlife.org
Clinical psychologist	Clinical psychologists diagnose, assess and treat people whose thought patterns and behaviour are a threat to their own and/or others' wellbeing. They work with different and varied client groups, which can include children with behavioural and emotional difficulties, those suffering from anxiety, post-traumatic stress, depression or addiction as well as more severe problems such as personality disorders.	British Psychological Society www.bps.org.uk

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Rehabilitation professional	Role	Further information
Psychiatrist	Psychiatrists work with patients with mental health problems such as depression, bipolar affective disorder, anxiety disorders, eating disorders, schizophrenia, dementia, and drug and alcohol abuse. A psychiatrist is a medically qualified doctor who deals with mental illness, as well as the interaction between physical and mental illness.	http://www.rcpsych.ac.uk/
Orthotist/ Prosthetist	Orthotists design and fit orthoses (calipers, braces and so on), which provide support to part of a patient's body to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing. Prosthetists provide care and advice on rehabilitation for patients who have lost or were born without a limb, fitting the best possible artificial replacement.	British Association of Prosthetists and Orthotists http://www.bapo.com
Radiographer: diagnostic/ therapeutic	Diagnostic radiographers produce high-quality images on film and other recording media, using all kinds of radiation. Therapeutic radiographers treat mainly cancer patients, using ionising radiation and, sometimes, drugs. They provide care across the entire spectrum of cancer services.	Society of Radiographers http://www.sor.org
Specialist social worker in England	Social workers work with individuals and families to help improve outcomes in their lives. They also manage some of the most challenging and complex risks for individuals and society. They take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties. This includes, but is not limited to, their vital role as the core of the approved mental health professional workforce.	British Association of Social Workers https://www.basw.co.uk
Speech and language therapist	Speech and language therapists work with people who have communication and/or swallowing difficulties.	Royal College of Speech & Language Therapists http://www.rcslt.org
Occupational health professional	Occupational health professionals are concerned with keeping people well at work – physically and mentally. This includes advising about workplace safety and the prevention of occupational injuries and disease, assessing fitness for work and helping to rehabilitate those who have suffered injury or sickness back into work.	The Society of Occupational Medicine https://www.som.org.uk/

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APPENDIX 3: CONDITIONS, KEY DOCUMENTS USED AND PREVALENCE

Evidence by condition to support the principles of good rehabilitation practice

Condition	Reference	Link	Demographic information
Acquired brain injury	*Head Injury.* Quality standard 74[90]	https://www.nice.org.uk/guidance/cg176	Head injury is the commonest cause of death and disability in people aged 1-40 years in the UK. Each year, 1.4m people attend emergency departments in England and Wales with a recent head injury. Between 33% and 50% of these are children aged under 15 years. Annually, about 200,000 people are admitted to hospital with head injury. Of these, one-fifth have features suggesting skull fracture or have evidence of brain damage.[90]

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Condition	Reference	Link	Demographic information
Amputees	*A Better Deal for Military Amputees*[91]	https://www.gov.uk/government/publications/a-better-deal-for-military-amputees	63,500 patient records remain open in the UK's amputee rehabilitation centres with almost 5,000 new patients being referred annually.[92]
	Evidence Based Clinical Guidelines for the Physiotherapy Management of Adults with Lower Limb Prostheses[93]	http://www.csp.org.uk/publications/evidence-based-clinical-guidelines-physiotherapy-management-adults-lower-limb-prosthese	
	Evidence Based Clinical Guidelines for the Physiotherapy Management of Adults with Lower Limb Prostheses. Quick reference guide[94]		
	Amputee & Prosthetic Rehabilitation: Standards & Guidelines[92]	http://www.bsrm.org.uk/publications/publications	
Armed forces personnel	*The Armed Forces Covenant: Today and Tomorrow*[95]	https://www.gov.uk/government/publications/the-armed-forces-covenant	

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Condition	Reference	Link	Demographic information
Cancer	*Cancer Rehabilitation: Making Excellent Cancer Care Possible*[14]	http://webarchive.nationalarchives.gov.uk/20130513211237/http:/www.ncat.nhs.uk/sites/default/files/work-docs/Cancer_rehab-making_excellent_cancer_care_possible.2013.pdf	There are 338,625 new cases of cancer each year. More than half of new cases are breast, lung, prostate or bowel cancer More than one-third of cancers are diagnosed in people aged over 75 years. Half of people diagnosed with cancer in England and Wales survive their disease for ten years or more. http://www.cancerresearchuk.org/health-professional/cancer-statistics/survival#heading-Zero
	Achieving World-class Cancer Outcomes: A Strategy for England 2015-2020[96]	http://www.cancerresearchuk.org/about-us/cancer-taskforce	
	Cancer Rehabilitation: An Overview and Prompt Tool[219]	http://www.londoncanceralliance.nhs.uk/media/116517/lca-rehabilitation-referral-prompt-tool-december-2015.pdf	

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Condition	Reference	Link	Demographic information
Cardiac	*Cardiac Rehabilitation*[97]	https://www.bhf.org.uk/publications/heart-conditions/cardiac-rehabilitation	In England, 44% of eligible patients (n=122,030) received cardiac rehabilitation in 2011-12.[99]
	National Service Framework for Coronary Heart Disease[8]	http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Longtermconditions/Vascular/Coronaryheartdisease/Nationalserviceframework/index.htm	
	Commissioning Cardiac Rehabilitation Services. Commissioning guide[98]	www.nice.org.uk/guidance/cmg40/chapter/2-an-integrated-approach-to-commissioning-high-quality-integrated-cardiac-rehabilitation	
Cerebral palsy	Guidelines currently being written by National Institute for Health and Care Excellence	http://www.scope.org.uk/Support/Parents-and-Carers/Landing/Cerebral-palsy/Ageing	It is estimated that 1 in 400 babies born in the UK have a type of cerebral palsy. Figures indicate that with the birth rate in excess of 700,000 per year, there may be as many as 1,800 new cases of cerebral palsy in children each year. http://www.cerebralpalsy.org.uk

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Condition	Reference	Link	Demographic information
Cystic fibrosis	*Standards for the Clinical Care of Children and Adults with Cystic Fibrosis in the UK*[100] *Standards of Care and Good Clinical Practice for the Physiotherapy Management of Cystic Fibrosis*[101] *Nutritional Management of Cystic Fibrosis*[102] *National Consensus Standards for the Nursing Management of Cystic Fibrosis*[103]	http://www.cysticfibrosis.org.uk/about-cf/publications/consensus-documents	The carrier rate of a cystic fibrosis gene mutation in the UK is 1 in 25 with an incidence of 1 in 2,500 live births. The population of people with cystic fibrosis in the UK is 9,027. The proportion and number of people who are adults with cystic fibrosis has increased. Over half (56%) are now 16 years or older.[100]

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Condition	Reference	Link	Demographic information
Diabetes	*Diabetes in Adults*[109]	https://www.nice.org.uk/guidance/conditions-and-diseases/diabetes-and-other-endocrinal-nutritional-and-metabolic-conditions/diabetes	6.2% of the population have diabetes; therefore the known diagnosed population is 3.3m people. https://www.diabetes.org.uk/About_us/What-we-say/Statistics/Diabetes-prevalence-2014/ 18,080 patients with diabetes underwent an amputation of some sort between 2007 and 2010 – an average of 116 a week. The figures rose to 21,125 in 2011-14, equating to 135 a week. In 2011-14 a total of 14,367 people lost a toe or part of their foot in minor amputations, and 6,758 had a foot or part of a leg cut off. http://www.theguardian.com/society/2015/jul/15/rise-diabetes-amputations-figures

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Condition	Reference	Link	Demographic information
Dementia	*Counting the Cost: Caring for People with Dementia on Hospital Wards*[104]	www.alzheimers.org.uk/countingthecost	Number of new cases each year: 25,000 per 100,000 in over 65-year-olds. 1 in 100 people have a diagnosis of dementia; 700,000 have the condition in the UK.[108]
	Prime Minister's Challenge on Dementia 2020[13]	https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020	
	Dementia: Supporting People with Dementia and their Carers in Health and Social Care. CG42.[105]	https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/dementia	
	Supporting People to Live Well with Dementia. Quality standard 30[106]	https://www.nice.org.uk/guidance/qs30	
	Facilitating Timely Diagnosis and Support for People with Dementia 2015/16. Enhanced service specification[107]	http://www.england.nhs.uk	

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Condition	Reference	Link	Demographic information
Elderly and frail elderly	*Continuity of Care for Older Hospital Patients: A Call for Action*[110]	www.kingsfund.org.uk/publications/continuity-care-older-hospital-patients	10m people in the UK are over 65 years old. The latest projections are for 5.5m more elderly people in 20 years' time and the number will have nearly doubled to around 19m by 2050. Within this total, the number of very old people grows even faster. There are currently 3m people aged more than 80 years and this is projected to almost double by 2030 and reach 8m by 2050. While 1 in 6 of the UK population is currently aged 65 and over, by 2050 1 in 4 will be. The average cost of providing hospital and community health services for a person aged 85 years or more is around three times greater than for a person aged 65 to 74 years. http://www.parliament.uk/business/publications/research/key-issues-for-the-new-parliament/value-for-money-in-public-services/the-ageing-population
	National Service Framework for Older People[x7]	https://www.gov.uk/government/publications/quality-standards-for-care-services-for-older-people	
	Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions. Draft for consultation, June 2015.[111]	https://www.nice.org.uk/guidance/indevelopment/gid-scwave0715	
	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[112]	https://www.england.nhs.uk	
Falls	*Falls in Older People: Assessment After a Fall and Preventing Further Falls*[113]	https://www.nice.org.uk/guidance/cg161	In the USA, over 700,000 patients a year are hospitalised because of a fall injury, most often because of a head injury or hip fracture. Adjusted for inflation, the direct medical costs for fall injuries are $34 billion annually. http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

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Condition	Reference	Link	Demographic information
Learning disabilities	*Models of Service Delivery for People with Learning Disabilities and Behaviour Challenges*. Draft scope[85]	https://www.nice.org.uk/guidance/population-groups/people-with-learning-disabilities	It is estimated that in 2015 there were 154,456 adults with critical and substantial needs using social care services.[87] In England in 2013 there were 1,068,000 people with learning disabilities: › 224,930 children (identified at School Action Plus or with Statements of SEN in Department for Education statistics as having either a primary or secondary special educational need associated with learning disabilities) › 900,900 adults with learning disabilities[88]
	Care and Support of Older People with Learning Disabilities. Draft scope[86]		
	Supporting People with a Learning Disability and/or Autism Who Have a Mental Health Condition or Display Behaviour that Challenges[89]	http://www.england.nhs.uk	

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Condition	Reference	Link	Demographic information
Long-term conditions	*Delivering Better Services for People with Long-term Conditions: Building the House of Care*[114]	http://www.kingsfund.org.uk/publications/delivering-better-services-people-long-term-conditions	19% of people in England have a limiting longstanding illness or disability. Unemployed people (those out of work but looking for work) were almost twice as likely as those in employment to have a limiting longstanding illness or disability (17% compared with 9%). In 2013, 69% of those aged 75 and over had a longstanding illness or disability. This compared with 15% of those aged 16 to 24.[117]
	National Service Framework for Long Term Conditions[6]	https://www.gov.uk/government/publications/quality-standards-for-supporting-people-with-long-term-conditions	
	Specialist Neuro-rehabilitation Services: Providing for Patients with Complex Rehabilitation Needs[115]	http://www.bsrm.org.uk/publications/publications	
	Standards for Rehabilitation Services Mapped on to the National Service Framework for Long Term Conditions[116]	http://www.bsrm.org.uk/publications/publications	
Multiple sclerosis	*Multiple sclerosis in adults: management*[118]	https://www.nice.org.uk/guidance/cg186	4 people per 100,000 population have a new diagnosis of multiple sclerosis each year. 144 people per 100,000 continue to live with the condition. 85,000 people in the UK have a diagnosis of multiple sclerosis.[108]

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Condition	Reference	Link	Demographic information
Parkinson's disease	*Parkinson's disease in over 20s: Diagnosis management*[119]	https://www.nice.org.uk/guidance/cg35	17 people per 100,000 population have a new diagnosis of PD each year. 200 people per 100,000 continue to live with the condition. 120,000 people in the UK have a diagnosis of PD.[108]
Prolonged disorders of consciousness	*Prolonged Disorders of Consciousness.* National clinical guidelines[220]	https://www.rcplondon.ac.uk/guidelines-policy/prolonged-disorders-consciousness-national-clinical-guidelines	
Major trauma	*Rehabilitation for Patients in the Acute Care Pathway Following Severe Disabling Illness or Injury*. BSRM core standards for specialist rehabilitation[120] *Specialist Rehabilitation in the Trauma Pathway*. BSRM core standards[12]	http://www.bsrm.org.uk/publications/publications	22 major trauma centres operate 24 hours a day, seven days a week and are staffed by consultant-led specialist teams with access to the best state-of-the-art diagnostic and treatment facilities. There are approximately 20,000 major trauma cases in England every year. https://www.gov.uk/government/news/new-major-trauma-centres-to-save-up-to-600-lives-every-year

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Condition	Reference	Link	Demographic information
	Major Trauma Measures. National peer review programme[121]		
	Trauma Handbook 2014. National peer review programme[122]		
	Major Trauma Networks 2013/2014. An overview of the findings from the 2013/14 national peer review of trauma networks in England[123]		
	NHS Standard Contract for Major Trauma Service (All Ages)[124]	https://www.england.nhs.uk	
Mental health	*No Health Without Mental Health: Implementation Framework*.[125]	https://www.gov.uk/government/publications/national-framework-to-improve-mental-health-and-wellbeing	About a quarter of the population will experience some kind of mental health problem in the course of a year, with mixed anxiety and depression the most common mental disorder in Britain. Women are more likely to have been treated for a mental health problem than men and about 10% of children have a mental health problem at any one time. Depression affects 1 in 5 older people. Suicides rates show that British men are three times as likely to die by suicide as British women. Self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population. http://www.mentalhealth.org.uk/help-information/mental-health-statistics/
	Whole-person Care: From Rhetoric to Reality (Achieving Parity Between Mental and Physical Health)[126]	http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx	
	Service User Experience in Adult Mental Health: Improving the Experience of Care for People Using Adult NHS Mental Health Services [9]	https://www.nice.org.uk/guidance/cg136	
	No Assumptions: A Narrative for Personalised, Coordinated Care and Support in Mental Health[83]	http://www.nationalvoices.org.uk/publications	

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Condition	Reference	Link	Demographic information
Mental health *(continued)*	*CQUIN 2014/15: Additional Guidance on the National Mental Health Indicator*[127]	https://www.england.nhs.uk	In an average class of 30 school children, 3 will suffer from a diagnosable mental health disorder. The most common conditions are conduct disorders, anxiety, depression and hyperkinetic disorders.[128]
	In sight and In Mind[222]	https://www.google.com/url?q=http://www.rcpsych.ac.uk/pdf/insightandinmind.pdf&sa=U&ved=0ahUKEwiat87px9bKAhUGfhoKHat_DlsQFggEMAA&client=internal-uds-cse&usg=AFQjCNH88ovikN_ELQ0QpA-co485WEX-MQ	Medically unexplained symptoms account for up to 20% of GP consultations[224] 30-60% of people in chronic pain have depression. Depression is four times more common in patients with low back pain (in primary care). Treating depression helps with pain, including arthritis.[224]
	Guidance for commissioners of rehabilitation services for people with complex mental health needs.[223]	http://www.rcpsych.ac.uk/pdf/rehab%20guide.pdf	
Musculoskeletal	*Musculoskeletal Rehabilitation*[129]	http://www.bsrm.org.uk/publications/publications	
Arthritis	*Osteoarthritis*. Quality standard 87[132]	https://www.nice.org.uk/guidance/cg177	In the UK, 8.75m people have sought treatment for osteoarthritis: › 33% of people aged 45 years and over › 49% of women and 42% of men of those aged 75 years and over http://www.arthritisresearchuk.org
	Rheumatoid Arthritis. Quality standard 33[133]	https://www.nice.org.uk/guidance/cg79	

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Condition	Reference	Link	Demographic information
	"Development of Patient-centred Standards of Care for Rheumatoid Arthritis in Europe: The eumusc.net Project". *Annals of the Rheumatic Diseases*[134]	http://ard.bmj.com/content/early/2013/08/06/annrheumdis-2013-203743.long	Rheumatoid arthritis costs the NHS an estimated £560m annually. The National Audit Office estimates that approximately 580,000 adults in England currently have the disease with a further 26,000 new cases diagnosed each year. https://www.nao.org.uk Based on new attendances to specialist paediatric rheumatologists in the UK, 10 in 100,000 children develop inflammatory arthritis each year.[135]
Hip fracture	*Hip Fracture*. Quality standard 16[131]	https://www.nice.org.uk/guidance/cg124	There were around 60,000 emergency hospital admissions for hip fracture in England in the financial year 2010/11 in adults aged 18 years or over. Of those, 54,000 underwent a hip fracture procedure.[131]
Low back pain	*Trauma Programme of Care Pathfinder Project: Low Back Pain and Radicular Pain*[130]	https://www.boa.ac.uk/pro-practice/commissioning-guidance-documents NB See also for foot and ankle; hands; hips; elbow and shoulder; and knees	UK-specific data shows that low back pain was the top cause of years lived with disability in both 1990 and 2010 – with a 12% increase over this time. Low back pain is extremely common and is the largest single cause of loss of disability adjusted life years, and the largest single cause of years lived with disability in England.[130]

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Condition	Reference	Link	Demographic information
Neurological	*Medical Rehabilitation in 2012 and Beyond*[137] *Long-term Neurological Conditions: Management of the Interface Between Neurology, Rehabilitation and Palliative Care*[138]	http://www.bsrm.org.uk/publications/publications	Each year 600,000 people (1% of the UK population) are newly diagnosed with a neurological condition. 10% of visits to A&E are for a neurological problem. 17% of GP consultations are for neurological symptoms. 19% of hospital admissions are for a neurological problem requiring treatment from a neurologist or neurosurgeon.[108]
Obesity	*Obesity: Identification, assessment and management*[139] *Physical Activity: Brief Advice for Adults in Primary Care*[141] *2013/14 NHS Standard Contract for Severe and Complex Obesity (All Ages)*[142] *Report of the Working Group into: Joined Up Clinical Pathways for Obesity*[143]	https://www.nice.org.uk/guidance/cg43 http://www.nice.org.uk/guidance/PH44 https://www.england.nhs.uk https://www.england.nhs.uk	One-third of children are overweight or obese.[140] In England, 24.8% of adults are obese and 61.7% are either overweight or obese. Today's obesity levels are more than three times what they were in 1980, when only 6% of men and 8% of women were obese. The UK has the highest level of obesity in Western Europe, ahead of countries such as France, Germany, Spain and Sweden. Obesity levels in the UK have more than trebled in the last 30 years and, on current estimates, more than half the population could be obese by 2050. http://www.nhs.uk/livewell/loseweight/pages/statistics-and-causes-of-the-obesity-epidemic-in-the-uk.aspx

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Condition	Reference	Link	Demographic information
Pain	*Guidelines for Pain Management Programmes for Adults*[144]	http://www.britishpainsociety.org.uk	Chronic pain is a common complaint in childhood and adolescence, with 25% of school-aged children reporting chronic or recurrent pain.[146]
	NHS Standard Contract for Specialised Pain[145]	https://www.england.nhs.uk	
Palliation	*Rehabilitative Palliative Care: Enabling People to Live Fully until They Die*[136]	http://www.hospiceuk.org/what-we-offer/clinical-and-care-support/rehabilitative-palliative-care	By 2035 hospices can expect that people aged 85 and older will account for more than 50% of deaths (328,469 deaths). Over the next ten years the incidence of cancer in the UK is projected to increase by 30% for men and 12% for women.[136]
	National Pain Audit final report 2010–2012[166]	http://www.nationalpainaudit.org	Over 5m people in the UK develop chronic pain, but only two-thirds will recover. It is estimated that 11% of adults and 8% of children suffer severe pain, representing 7.8m people in the UK. Using health surveys, the average annual incidence is estimated at 8.3% with an annual average recovery rate of 5.4%. Pain services can significantly help to improve quality of life (70%), the degree by which pain interferes with lives (76%) and to a lesser extent pain relief.[166] Pain is the second most common reason for claiming incapacity benefits costing £3.8bn annually. http://www.policyconnect.org.uk/cppc/about-chronic-pain

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Condition	Reference	Link	Demographic information
Pulmonary	"BTS Guideline on Pulmonary Rehabilitation in Adults", *Thorax*[147]	www.brit-thoracic.org.uk/guidelines-and-quality-standards/pulmonary-rehabilitation-guideline/	
	Chronic Obstructive Pulmonary Disease. Quality standard[148]	https://www.nice.org.uk/guidance/cg101	
Spinal cord injury	*Chronic Spinal Cord Injury: Management of Patients in Acute Hospital Settings*[149]	http://www.researchgate.net/publication/5516031_Chronic_spinal_cord_injury_management_of_patients_in_acute_hospital_settings	Spinal cord injury is a lifelong condition affecting over 40,000 people in the UK.[149]
	NHS Standard Contract for Spinal Cord Injuries (All Ages)[150]	https://www.england.nhs.uk/?s=spinal+cord+injuries&site=	

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Condition	Reference	Link	Demographic information
Stroke	*Stroke rehabilitation in adults*[16]	http://www.nice.org.uk/guidance/conditions-and-diseases/cardiovascular-conditions/stroke-and-transient-ischaemic-attack	In the UK, 240 per 100,000 population have a stroke every year. 500 people per 100,000 continue to live with the condition. 300,000 people in the UK have a diagnosis of stroke.[108] Stroke occurs in up to 13 per 100,000 children in the UK. It is thought there are around 400 childhood strokes a year in the UK.[153]
	National Clinical Guidelines for Stroke 4th ed. Intercollegiate Stroke Working Party[213]	https://www.rcplondon.ac.uk/resources/stroke-guidelines	
	Sentinel Stroke National Audit Programme[74]	https://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme	
	Post-acute Organisational Audit. Public report[75]		
	Stroke Association Manifesto 2010 to 2015[152]	www.politicsresources.net/area/uk/ge10/man/groups/stroke.pdf	
	Community stroke rehabilitation. East Midlands Strategic Clinical Networks. 2014	http://emahsn.org.uk/stroke-rehabilitation/stroke-rehabilitation-projects/	
	Evidence-based community stroke rehabilitation services. East Midlands Academic Health Science Network & Strategic Clinical Network	http://emahsn.org.uk/stroke-rehabilitation/stroke-rehabilitation-projects	

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Condition	Reference	Link	Demographic information
Transsexual, Transgender, and Gender-Nonconforming People	*Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.*[222]	http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655	
Vocational	*Standards of Practice and Code of Ethics for Vocational Rehabilitation Practitioners*[154]	http://www.vra-uk.org/node/13vr	
	Vocational Assessment and Rehabilitation for People with Long-term Neurological Conditions: Recommendations for Best Practice[155]	http://www.bsrm.org.uk/publications/publications	
	Vocational Assessment and Rehabilitation after Acquired Brain Injury. Inter-agency guidelines[156]	http://www.bsrm.org.uk/publications/publications	

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Condition	Reference	Link
Other relevant document		
Patient experience and "I" statements	*Patient Experience in Adult NHS Services*[76]	https://www.nice.org.uk/guidance/cg138
	Hard Truths: The Journey to Putting Patients First. Vol 1[157]	
	Hard Truths: The Journey to Putting Patients First. Vol 2[20]	
	National Audit for Intermediate Care: Patient Reported Experiences[77]	http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-three.php
	Rehabilitation, Reablement and Recovery: Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation[26]	http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/
	I'm Still Me: A Narrative for Coordinated Support for Older People[81]	http://www.nationalvoices.org.uk/publications
	Person Centred Care 2020: Calls and Contributions from Health and Social Care Charitie[82]	http://www.nationalvoices.org.uk/publications
	The Narrative for Person Centred Coordinated Care[78]	http://www.nationalvoices.org.uk/person-centred-coordinated-care
	Integrated Care: What do Patients, Service Users and Carers Want?[79]	www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf
	Principles of Integrated Care[80]	http://www.nationalvoices.org.uk/principles-integrated-care

NHS England

Condition	Reference	Link
Equipment	*NHS Standard Contract for Complex Disability Equipment: Specialised Wheelchair and Seating Services (All Ages)*[158]	https://www.england.nhs.uk
	Improving the Quality of Orthotics Services in England[60]	http://www.england.nhs.uk
Generic	*Care Act 2014*[159]	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm
	CCG Assurance Framework 2015/16[160]	https://www.england.nhs.uk/commissioning/ccg-auth/
	The Fundamental Standards[70]	http://www.cqc.org.uk/content/fundamental-standards
	High Quality Care for All: The NHS Next Stage Review. Final report[161]	http://www.kingsfund.org.uk/publications/briefing-high-quality-care-all-nhs-next-stage-review-final-report
	The NHS Constitution for England[162]	https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
	Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[163]	http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report
	Transforming Care: A National Response to Winterbourne View Hospital[164]	https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response
	Better Leadership for Tomorrow: NHS Leadership Review[165]	https://www.gov.uk/government/publications/better-leadership-for-tomorrow-nhs-leadership-review
	The NHS Outcomes Framework 2015/16[28]	https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015
	The Adult Social Care Outcomes Framework 2015/16[29]	https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016

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Condition	Reference	Link
Generic *(continued)*	*Improving Outcomes and Supporting Transparency. Part 1A: A Public Health Outcomes Framework for England, 2013-2016*[30]	https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency
	Ready to Go? Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care[167]	http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113950
	Focus On: Allied Health Professionals – Can We Measure Quality of Care?[168]	http://www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/Focus%20On%20Allied%20Health%20Professionals.pdf
	How do Quality Accounts Measure Up? Findings from the first year[68]	http://www.kingsfund.org.uk/publications/how-do-quality-accounts-measure
	Making Change Possible: A Transformation Fund for the NHS[169]	http://www.kingsfund.org.uk/publications/making-change-possible?gclid=CL2HssPh-8gCFYgKwwodAaAODw
	Securing Equity and Excellence in Commissioning Specialised Services[170]	http://www.hscic.gov.uk/article/2684/Prescribed-Specialised-Services
	Everyone Counts: Planning for Patients 2013/14[171]	http://www.england.nhs.uk/everyonecounts/
	The Five Year Forward View[19]	https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
	Personalised Care and Support Planning Handbook: The Journey to Person-centred Care[172]	http://personcentredcare.health.org.uk/resources/personalised-care-and-support-planning-handbook-journey-person-centred-care
	The Government's Mandate to NHS England for 2016-17[31]	https://www.gov.uk/government/publications/nhs-mandate-2016-to-2017

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Condition	Reference	Link
Generic *(continued)*	*Transforming Participation in Health and Care*[173]	http://www.england.nhs.uk/ourwork/patients/participation
	Improving Adult Rehabilitation Service in England: Sharing Best Practice in Acute and Community Care[52]	http://www.nhsiq.nhs.uk/resource-search/publications/improving-adult-rehabilitation-services-in-england
	Rehabilitation, Reablement and Recovery. Quality guidance document[61]	http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/
	Rehabilitation, Reablement and Recovery. Quality guidance document. Quick reference guide[175]	http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/
	Better Value in the NHS: The Role of Changes in Clinical Practice[176]	http://www.kingsfund.org.uk/publications/better-value-nhs
	Commissioning for Carers: Principles and Resources to Support Effective Commissioning for Adult and Young Carers[177]	https://www.england.nhs.uk
	Guidance on Delivering Personalised Care and Support Planning: The Journey to Person-centred Care. Supplementary information for commissioners[178]	http://www.england.nhs.uk
	Personalised Health and Care 2020. *Using Data and Technology to Transform Outcomes for Patients and Citizens: A Framework for Action*[84]	https://www.gov.uk/government/publications/personalised-health-and-care-2020

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Condition	Reference	Link
	Avoiding Unplanned Admissions: Proactive Case Finding and Patient Review for Vulnerable People 2015/16. Enhanced service specification[179]	http://www.england.nhs.uk
Research and education	*Beyond Crisis: Making the Most of Health Higher Education and Research*[180]	http://www.councilofdeans.org.uk/wp-content/uploads/2015/03/COD_A4_4pp_v1.2web.pdf
	Your Guide to our Standards for Continuing Professional Development[181]	http://www.hcpc-uk.co.uk/publications/index.asp?action=submit#publicationSearchResults

NHS England

APPENDIX 4: NHS, PUBLIC HEALTH AND SOCIAL CARE OUTCOME DOMAINS

NB black text = outcomes that ARE influenced by rehabilitation intervention

The NHS Outcomes Framework 2015/16 (28)		
Domain 1	Preventing people from dying prematurely — Potential years of life lost (PYLL) from causes considered amendable to healthcare (life expectancy at 75)	
	Outcomes influenced by rehabilitation intervention	
	Reducing premature mortality from the major causes of death	Under 75 mortality rate from cardiovascular disease Under 75 mortality rate from respiratory disease Under 75 mortality rate from liver disease Under 75 mortality rate from cancer i One- and ii Five-year survival from all cancers iii One- and iv Five-year survival from breast, lung and colorectal cancer v One- and vi Five-year survival from cancers diagnosed at stage 1&2
	Reducing premature death in people with mental illness	Excess under 75 mortality rate in adults with common mental illness Suicide and mortality from injury of undetermined intent among people with recentcontact from NHS services
	Reducing deaths in babies and young children	Infant mortality Five-year survival from all cancers in children
	Reducing premature death in people with a learning disability	Excess under 60 mortality rate in adults with a learning disability

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Domain 2	Enhancing quality of life for people with long-term conditions (Health-related quality of life for people with long-term conditions)	
	Ensuring people feel supported to manage their condition	Proportion of people feeling supported to manage their condition
	Improving functional ability in people with long-term conditions	Employment of people with long-term conditions
	Reducing time spent in hospital by people with long-term conditions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Unplanned hospitalisation for asthma, diabetes and epilepsy in a under 19s
	Enhancing quality of life for carers	Health-related quality of life for carers
	Enhancing quality of life for people with mental illness	Employment of people with mental illness Health-related quality of life for people with mental illness
	Enhancing quality of life for people with dementia	Estimated diagnosis rate for people with dementia A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life
	Improving quality of life for people with multiple long-term conditions	Health-related quality of life for people with three or more long-term conditions

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Domain 3	**Helping people to recover from episodes of ill health or following injury; Emergency admissions for acute conditions that should not usually require hospital admission; Emergency readmissions within 30 days of discharge from hospital**	
	Improving outcomes from planned treatments	Total health gain as assessed by patients for elective procedures Physical health-related procedures Psychological therapies Recovery in quality of life for patients with mental illness
	Preventing lower respiratory tract infections (LRTI) in children from becoming serious	Emergency admissions for children with LRTI
	Improving recovery from injuries and trauma	Survival from major trauma
	Improving recovery from stroke	Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
	Improving recovery from fragility fractures	Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days
	Helping older people to recover their independence after illness or injury	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service Proportion offered rehabilitation following discharge from acute or community hospital
	Dental health	Decaying teeth (PHOF 4.02**) Tooth extractions in secondary care for children under 10

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Domain 4	**Ensuring that people have a positive experience of care; Patient experience of primary care i) GP Services ii) GP Out of Hours services; Patient experience of hospital care; Friends and family test**	
	Improving people's experience of outpatient care	Patient experience of outpatient services
	Improving hospitals' responsiveness to personal needs	Responsiveness to in-patients' personal needs
	Improving people's experience of accident and emergency services	Patient experience of A&E services
	Improving access to primary care services	Access to i GP services and ii NHS dental services
	Improving women and their families' experience of maternity services	Women's experience of maternity services
	Improving the experience of care for people at the end of their lives	Bereaved carers' views on the quality of care in the last 3 months of life
	Improving experience of healthcare for people with mental illness	Patient experience of community mental health services
	Improving children and young people's experience of healthcare	Children and young people's experience of inpatient services
	Improving people's experience of integrated care	People's experience of integrated care

NHS England

Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm. Deaths attributable to problems in healthcare; Severe harm attributable to problems in healthcare	
	Reducing the incidence of avoidable harm	Deaths from venous thromboembolism (VTE) related events Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile Proportion of patients with category 2, 3 and 4 pressure ulcers Hip fractures from falls during hospital care
	Improving the safety of maternity services	Admission of full-term babies to neonatal care
	Improving the culture of safety reporting	Patient safety incidents reported

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The Adult Social Care Outcomes Framework 2015/16 (29)		
Domain 1	**People manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to meet their needs**	
	Carers can balance their caring roles and maintain their desired quality of life	
	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.	Proportion of adults with a learning disability in paid employment 1.8, NHSOF 2.2). Proportion of adults in contact with secondary mental health services in paid employment. Proportion of adults with a learning disability who live in their own home or with their family. Proportion of adults in contact with secondary mental health services living independently, with or without support. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.
Domain 2	**Delaying and reducing the need for care and support – Permanent admissions to residential and nursing care homes, per 100,000 population**	
	Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.	
	Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.	
	When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.	

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Domain 3	**Ensuring that people have a positive experience of care and support**	
	People who use social care and their carers are satisfied with their experience of care and support services	
	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.	The proportion of people who use services and carers who find it easy to find information about support.
	People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual. This information can be taken from the Adult Social Care Survey and used for analysis at the local level.	
	Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm – The proportion of people who use services who feel safe	
	Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish.	
Domain 4	**Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm** Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm. People are protected as far as possible from avoidable harm, disease and injuries. People are supported to plan ahead and have the freedom to manage risks the way that they wish.	
	Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services.	

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Improving Outcomes and Supporting Transparency. Part 1A: A Public Health Outcomes Framework for England, 2013-2016 (30)		
Domain 1	**Improving the wider determinants of health, Improvements against wider factors that affect health and wellbeing and health inequalities.**	Indicators Children in poverty School readiness Pupil absence First-time entrants to the youth justice system 16-18 year olds not in education, employment or training Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation People in prison who have a mental illness or a significant mental illness Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services Sickness absence rate Killed and seriously injured casualties on England's roads Domestic abuse Violent crime (including sexual violence) Re-offending levels The percentage of the population affected by noise Statutory homelessness Utilisation of green space for exercise/health reasons Fuel poverty Social isolation Older people's perception of community safety.

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Domain 2	**Health improvement; People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities.**	Indicators Low birth weight of term babies Breastfeeding Smoking status at time of delivery Under 18 conceptions* Child development at 2-2½ years (under development) Excess weight in 4-5 and 10-11 year olds* Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years Emotional well-being of looked after children Smoking prevalence – 15 year olds (placeholder) Self-harm Diet Excess weight in adults Proportion of physically active and inactive adults Smoking prevalence – adult (over 18s) Successful completion of drug treatment People entering prison with substance dependence issues who are previously not known to community treatment Recorded diabetes Alcohol-related admissions to hospital Cancer diagnosed at stage 1 and 2 Cancer screening coverage Access to non-cancer screening programmes Take up of the NHS Health Check Programme – by those eligible* Self-reported wellbeing Falls and injuries in people aged 65 and over.

NHS England

Domain 3	Health protection; The population's health is protected from major incidents and other threats, while reducing health inequalities.	Indicators Fraction of mortality attributable to particulate air pollution Chlamydia diagnoses (15-24 year olds)* Population vaccination coverage People presenting with HIV at a late stage of infection Treatment completion for Tuberculosis (TB) Public sector organisations with board-approved sustainable development management plan Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies*.
Domain 4	**Healthcare public health and preventing premature mortality; Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.**	Indicators Infant mortality Tooth decay in children aged 5 Mortality from causes considered preventable Mortality from all cardiovascular diseases (including heart disease and stroke) Mortality from cancer Mortality from liver disease Mortality from respiratory diseases Mortality from communicable diseases Excess under 75 mortality in adults with serious mental illness Suicide rate Emergency readmissions within 30 days of discharge from hospital Preventable sight loss Health-related quality of life for older people Hip fractures in people aged 65 and over Excess winter deaths Estimated diagnosis rate for people with dementia.

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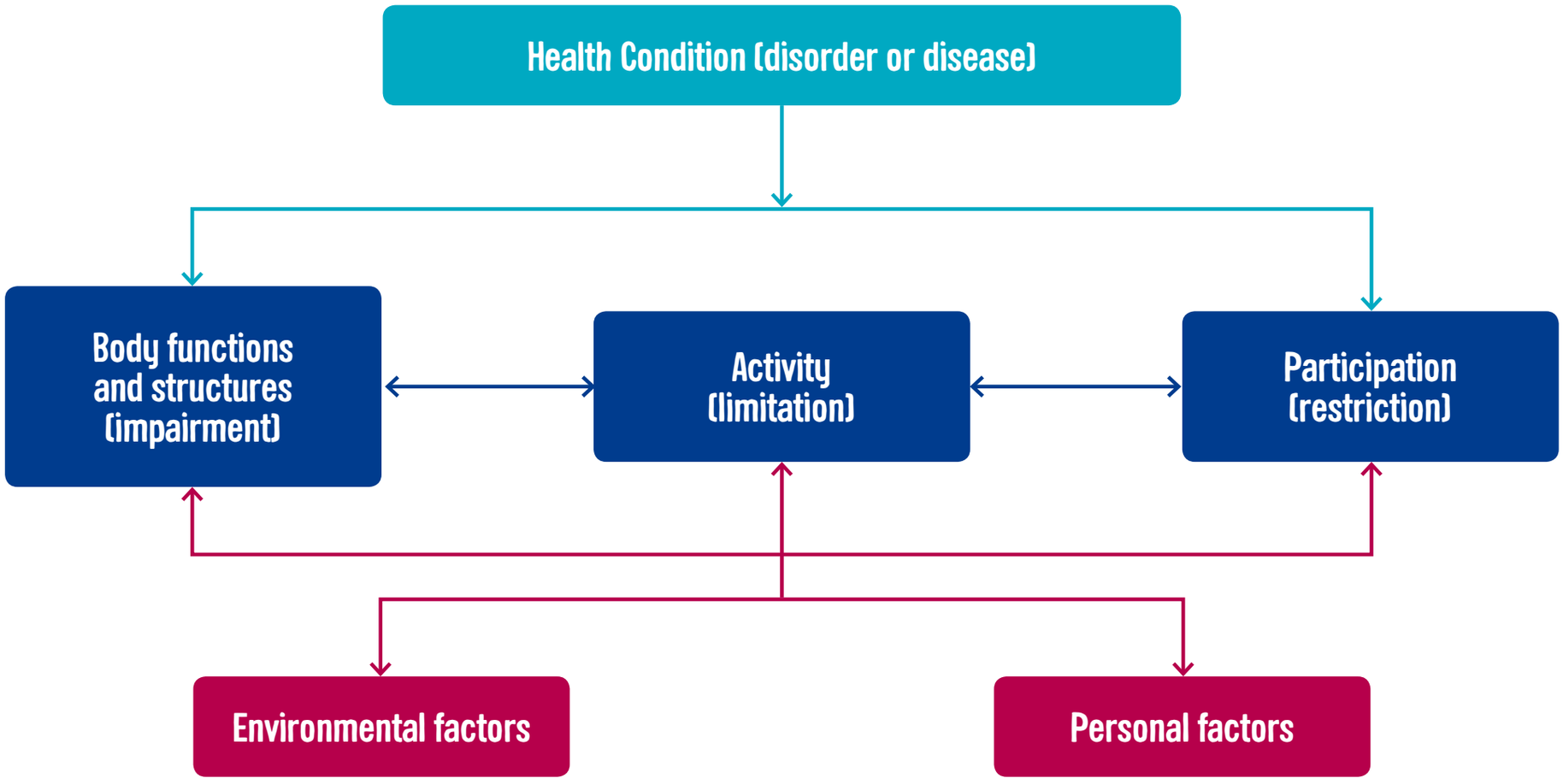
APPENDIX 5: WORLD HEALTH ORGANIZATION – INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH DIAGRAM



Interactions between components of the World Health Organisation's International *Classification of Functioning, Disability and Health*[24]

APPENDIX 6: EXAMPLES OF GOOD PRACTICE

Example of good practice	Web link	Region	Key terms
A. Making carers welcome in mental health Worcestershire Health and Care Trust Older Patient Inpatient Mental Health Service Dr Natasha Lord, clinical psychologist	http://www.fabnhsstuff.net/2015/11/18/making-carers-welcome-mental-health/	Midlands and East of England	Older people Mental Health Carer support

It is demonstrably clear that a hospital stay can be a distressing, scary and potentially damaging experience for a person with dementia or for those with mental health difficulties, and that the close involvement of their carers hugely improves the quality of their care.

Carers have an intimate knowledge of the patient and can support and comfort them. But these carers also need support, comfort and recognition, and at Worcestershire Health and Care Trust Older Patient Inpatient Mental Health Service, we are working to make this happen.

We want to care for the carer. To encourage carer engagement, we work with them to get a full life story of the vulnerable patient, finding out about their past work, their family life, their needs and preferences, likes and dislikes – nursing staff always need to think of the patient as a unique person. Carers are encouraged to be actively involved in the patient's care. At the same time, we recognise that hospitals can be intimidating places.

We want to welcome carers. When they arrive we give them a carers' leaflet so that they know what resources are available and what they can expect during their loved one's time in hospital. They can stay with the patient and there is also a carers' room – a dedicated space, where carers can access information, find support and help, or stay overnight if this is what they need.

Carers should not feel alone. There is a dedicated carer link on each ward, who will make initial contact with the families, ensure that a carer assessment has been offered and provide support throughout their loved one's stay in hospital. If more intensive support is needed, this is provided. Moreover, once a week, we hold a carers' forum – a weekly informal drop-in where carers are actively asked to raise concerns or ask questions. Alongside this, we have educational support for carers, giving books on prescription, links to external services and tailored sessions. In this way we hope to make carers into a valued and supported community.

We wholeheartedly support John's Campaign, which is about compassionate care for all of our patients and about recognition of the vital role that a carer has to play.

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Example of good practice	Web link	Region	Key terms
B. Physical health overhaul for patients with mental illness Halton and Warrington Early Intervention Team at 5 Boroughs Partnership NHS Trust	http://www.fabnhsstuff.net/2015/08/17/physical-health-overhaul-for-patients-with-mental-illness/	North of England	Physical health and mental health Pathway

A support, 'time and recovery' worker has dramatically improved the physical health of patients being treated for mental illness by overhauling screening, monitoring and support. The time and recovery worker, who works for the Halton and Warrington Early Intervention Team at 5 Boroughs Partnership NHS Trust, established and developed a physical health and wellbeing pathway for patients after an audit showed screening was poor.

'We know from national research about the importance of physical health needs,'. 'People with mental illness are at increased risk of physical ill-health, especially individuals with schizophrenia or bipolar disorder, who die on average 16-25 years sooner than the general population. Yet less than 30% of people with schizophrenia receive annual physical health screenings'.

First, service users' physical health records were audited. Only 6% had received a baseline comprehensive health screening, falling to just 3% at the two-year stage of their treatment. the time and recovery worker used the Royal College of Psychiatrists' Lester cardio-metabolic tool – a simple assessment and intervention framework focusing on smoking, lifestyle, BMI, blood pressure, glucose regulation and blood lipids – for patients receiving antipsychotic medication as a template and combined it with the trust's own comprehensive physical health assessment document.

Next the time and recovery worker established a steering group linked to primary care, secondary care and included service user representatives and produced an educational DVD, featured on the trust's website, and a GP leaflet detailing the importance of physical health screenings during treatment for a severe mental illness.

And as there was no IT structure available to record and track screening results, the time and recovery worker created a evidence-based database, embedding best practice guidelines. 'It highlights when service users' screenings are due to both myself and their care coordinator to ensure the appointment is booked,' says the time and recovery worker. 'It is a great system that I can pass on to people who need it. It was submitted to NICE and has been published as an example of best practice.'

After training to improve clinical skills, the time and recovery worker developed health and wellbeing clinics. 'It had been difficult to get other people to do the screenings – with the clinics I knew I could make a real difference. I also organised screenings in people's homes that were carried out with local wellbeing nurses,'. The clinics mean we can make sure the patient is screened and then send a corresponding letter to the GP. In Halton I share the work with the wellbeing nurses, they will go out and see difficult patients and we swap information.'

The time and recovery worker signposts people for smoking cessation or gym membership where required, and holds regular and ongoing weight management/healthy lifestyle sessions – particularly for those who may be obese and need encouragement and support to adopt a healthier lifestyle (see case study, below). As a result of the screening programme, a number of clients with issues such as significantly raised blood pressure, undiagnosed high cholesterol and weight management problems have now had them addressed.

A re-audit shows an impressive dramatic increase in adherence to screenings – from 6% to 94% overall. Follow up as well as baseline screenings are completed and all results recorded and shared with GP practices. Intervention plans are initiated immediately, with weekly follow up appointments and screenings.

Attitudes in the early intervention team have also changed. 'Initially the team was not sure what I was doing and why, although my manager was completely on board. They were focused on only the mental health aspect of their service users' treatment. Now the whole team is on board and want the screenings for their patients.'

The trust plans to introduce a similar assistant practitioner role in each early intervention team. The time and recovery worker already plans for the future of service: 'We want to create a one-stop shop for physical screening instead of sending people to different appointments. I am also hoping to facilitate a service user-led health and wellbeing group, so they can work together and take the initiative for themselves'.

You can read a full case study report here http://rcni.com/newsroom/nurse-awards/physical-health-overhaul-patients-mental-illness-26141

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Example of good practice	Web link	Region	Key terms
C. Grove Avenue Birmingham and Solihull Mental Health NHS Foundation Trust	http://www.nhs.uk/Services/clinics/Services/Service/DefaultView.aspx?id=253793	Midlands and East of England	Mental Health Trans-agency working

Birmingham and Solihull Mental Health NHS Foundation Trust, is a non-acute inpatient service housed in a community rehabilitation unit. This service is for adults aged 18 to 65 with a treatment-resistant, serious and enduring mental illness such as schizophrenia, schizoaffective disorder, bipolar affective disorder or other psychoses. The aim of the service is to support individuals with their rehabilitation needs as part of their recovery journey. They offer a variety of approaches and interventions to support individual needs delivered by an interdisciplinary team, working in partnership with physical health services in acute and primary care, the third sector and the local community. Each service user is actively involved with their rehabilitation programme to ensure identification and support of all their aspirations and goals. The user centred care plans are holistic, covering the following domains; Symptom recovery (my mental health recovery), Physical recovery (staying healthy), Functional recovery (my life skills), Social recovery (my relationships), Occupational recovery (my interests), Habilitation (my general support needs), and Substance use (my drug and alcohol use). There is a weekly review of short term goals and three month assessment which looks at the person's view of their recovery, where they are, their engagement in the rehabilitation, any challenging behaviours that occur/have occurred, their resettlement and how to attend to areas such as finance, and managing their own mental and physical health.

NHS England

Example of good practice	Web link	Region	Key terms
D. Principia Partners in Health Southern Nottinghamshire Lakeside Healthcare Group	https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/community-sites/#twentythree	Midlands and East of England	Trans-agency working

(Patient population: 126,000)

Principia is constituted as a Community Interest Company and has three stakeholders classes: Rushcliffe GP practices; Rushcliffe community services providers; and the 126 000 registered population of Rushcliffe. GP practices in Rushcliffe have come together and are establishing a new and unique primary care partnership and organisation, which will lead on and indeed own the transformation of general practice and develop the progressive model which will be the base component and platform of the Multi speciality community provider. Principia and Partners Health will also be joined by health and social care partners who have committed their enthusiastic support as part of our local South Nottinghamshire transformation work. NHS Rushcliffe CCG is the sponsor, and the programme has the support of the patient and voluntary sector groups, which represent the local population.

The proposal is to establish an MCP defined by a culture of mutual accountability, commitment and pride. This will accept contractual responsibility for the health, and the quality and costs of care for the local population within the capitated resource allocated. This will be achieved through a new model of integrated care which is focussed on early intervention, living well at home and avoiding unnecessary use of the hospital. The impact will be a reduction in fragmentation, delays, duplication and inefficiencies experienced by patients and carers. Care will be delivered closer to patients' homes resulting in an enhanced experience and improved clinical outcomes, and better use of available resources. The MCP will move to have a capitated outcomes based contract which will cover health and social care.

So patients, for example an elderly married couple who live in a small rural village outside of West Bridgford and have done so since they retired, will benefit when the new accountable care organisation is in place. The couple, who both have multiple long term conditions, can expect to have a proactive care plan in place which is discussed with their local health and care team on a regular basis. This conversation will build confidence and capability for the married couple to make good decisions about what they do to keep themselves fit and well and also when they need to escalate the level of support they need irrespective of the time of the day or week. When they do, a provider will be able to respond to all their care needs, and in which all the participants are working with a common goal: maximising outcomes as efficiently as possible.

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Example of good practice	Web link	Region	Key terms
E. The Adult Ability team Staffordshire and Stoke on Trent Partnership NHS Trust Staffordshire and Stoke on Trent Partnership NHS Trust	https://www.staffordshireandstokeontrent.nhs.uk/Services/adult-ability-team.htm	North of England	Trans-agency working Long term conditions

Staffordshire and Stoke on Trent Partnership NHS Trust, is a community based interdisciplinary team of professionals working together to provide continued case management, specialist nursing and neuro-rehabilitation to those in East Staffordshire with a diagnosis of a Progressive Neurological Condition. Self-management is intrinsic to the philosophy of care; 'Through proactive client centred case management and therapeutic interventions the main purpose of the Adult Ability Team is to support people to self-manage their condition as autonomously as possible, optimising maintenance of physical, psychological and social functioning, by being accessible throughout the entire trajectory of the condition from diagnosis to end of life, responding both to acute episodes and long term management. The impact of delivering a community based service with single point of access and a philosophy of care based on an enabling theory is that there are fewer GP contacts and hospital admissions, patients are supported to maintain occupation and outcomes indicated by use of Therapy Outcome Measures; Impairment (problems in body structure or function), Activity (performance of activities), Participation (disadvantages experienced in life situations) and Wellbeing (emotional level of upset or distress).

Example of good practice	Web link	Region	Key terms
F. Waistlines Staffordshire and Stoke on Trent Partnership NHS Trust	https://www.staffordshireandstokeontrent.nhs.uk/BoardMeetings/lose-weight-with-waistlines.htm	North of England	Obesity Physical Activity

Waistlines

Staffordshire and Stoke on Trent Partnership NHS Trust, is a free, personalised adult weight management service covering Staffordshire. The service offers lifestyle and weight management services to anyone who would benefit from weight loss. The team help clients to set goals make healthy lifestyle choices and maintain their target weight. The Waistlines Service holds a variety of local clinics and group workshops running throughout the week, including evening and weekend options. The service also includes support to access physical activity opportunities and work in partnership with a number of local providers to ensure we provide a holistic service to our patients. The team has helped 86% of patients lose weight by the end of their plan with an average waist circumference reduction of 5.7cm.

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Example of good practice	Web link	Region	Key terms
G. Integrated respiratory services: Hospitals without walls, inner London Lambeth and Southwark CCGs King's Health Partners Academic Health Sciences Centre.	http://www.fabnhsstuff.net/2015/07/27/integrated-respiratory-services-hospitals-without-walls/	London	Trans-agency working Respiratory medicine

Integrated respiratory services: Hospitals without walls

Key recommendations

- Review of respiratory patients by a 7 day multidisciplinary integrated respiratory team (IRT) promotes accurate diagnosis and acute management, and helps to prioritise inpatients for a respiratory bed.
- Working with community rapid response and hospital at home services enables admission avoidance and early supported discharge where this is appropriate.
- All clinicians looking after patients with long-term conditions need training in collaborative care planning, including those in an acute setting. Care plans should be co- created with patients and shared with their primary care team.
- Respiratory 'virtual clinics' allow joint working between primary care and specialist teams to systematically review the diagnosis and long-term management of respiratory patients
- Engagement, support and long-term commitment by local clinical commissioning groups (CCGs) are critical enablers for integrated teams
- A well-defined team purpose, strong leadership, robust communication, clear competencies and a supportive approach allow the patient and staff benefits of integrated working to be realised over time.

The challenge

Our aim is to improve the respiratory health of an inner London population with high deprivation and smoking rates, and high premature mortality due to respiratory disease.

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Local context

Our local population consists of around 600,000 people, served by two clinical commissioning groups (Lambeth and Southwark CCGs). King's Health Partners (KHP) includes two large teaching hospitals and a mental health trust providing acute and community services within an Academic Health Sciences Centre.

Our solution

The multidisciplinary integrated respiratory team (IRT) at KHP has a vision of 'teams without walls'. We aim to bring specialist care closer to the patient. The purpose of the service is to ensure that patients living with a long-term lung condition, and their carers, experience high value, collaborative and coordinated care wherever they need it. Our guiding principles are right care and value based healthcare.

We work in an integrated way across two acute hospitals and the community delivering chronic obstructive pulmonary disease (COPD), oxygen, pulmonary rehabilitation and supported discharge services. Key components include the IRT working in acute trusts supporting accurate diagnosis and acute management, communication and post discharge care, virtual clinics (VCs) in the community, a single point of referral to IRT from the community and optimising respiratory prescribing.

Engagement, support and long-term commitment by the local CCGs have been critical enablers for the development of the IRT. A well-defined team purpose, strong leadership, robust communication, clear competencies and a supportive approach allow the patient and staff benefits of integrated working to be realised over time. Promoting professional development, sharing success and reflecting on difficult experiences have helped the IRT to keep a sense of purpose and momentum.

Outcomes

There has been a marked reduction in acute COPD admissions to Kings College Hospital (within appropriate healthcare resource groups groups) from 296 in 2012-13 to 196 in 2014-15 (a 34% decrease). Total COPD admissions have also decreased by 8%. Length of stay for COPD admissions (within appropriate HRG groups) has reduced from 4.45 to 3.7 days (a 17% decrease).

The focus in our respiratory virtual clinics (VCs) is to promote evidence-based high value care and to reduce spend on inappropriate inhaled medications, which can then be reinvested elsewhere in the pathway. Both Lambeth and Southwark have seen reductions in the proportion of therapy prescribed as high dose steroid inhalers in the time the VCs have been running. It is estimated that this has saved £200,000 in 12 months in just one CCG. A proportion of this has been reinvested in the high value treatments which have seen more demand from primary care as a result of awareness raising through the VCs, eg community pulmonary rehabilitation.

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Staffing

The IRT consists of specialist respiratory nurses, physiotherapists, a respiratory pharmacist and a smoking cessation advisor, working seven days a week across two acute hospital sites. There are seven staff members on each acute site, of whom a minimum of two are based in the community on a rotational basis. The team is led by an integrated respiratory consultant and two locality GP respiratory leads.

Methods

A number of initiatives have allowed us to improve care for respiratory patients across KHP:

- Seven day working of the team aims to ensure that every bed-day counts for patients admitted to hospital with exacerbations of airways disease.
- Close links with the emergency department, smoking cessation services, hospital and community pharmacy, clinical psychology, community mental health, dietetics and palliative care to ensure coordinated care.
- Aiming for every patient to have a person-centred specialist review, focused on collaborative care planning, and for patients to have a supported discharge including the use of the COPD Discharge Care Bundle.
- Working with community rapid response and hospital at home services on admission avoidance and early supported discharge where appropriate.
- Follow up of patients by telephone and at home post discharge, working with other agencies to coordinate onward care, as patients are often elderly, breathless and have complex co-morbidities or social issues.
- A seven-day telephone advice line for patients and local GPs.
- A single point of referral in the community, which means that referral to any of the IRT services from primary care comes first to one of the two locality GP leads, enabling peer-to-peer support and ensuring patients receive the right care in the right place first time.
- Respiratory virtual clinics which run twice a week in primary care. The focus of VCs is joint working between primary care teams and the IRT to systematically review the diagnosis and long-term management of the respiratory patient caseload. VCs have resulted in major shifts in the focus of COPD care in Lambeth and Southwark, supporting responsible respiratory prescribing and reducing harm and waste through inappropriate use of inhaled therapies.

What next?

Communication barriers are a constant challenge, with IT systems that are not fully joined up across the health and social care sectors. Electronic patient records help to allow multiple sites to share information about patients and this is an evolving process.

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Patient feedback

Inspired by the care they received, one of our patients wrote a poem to express their feelings about their experience.

> "You do things, then disappear,
> You're so unassuming It's as if you were never here.
> But you were, You are, You're everywhere.
> You are the ones who really care"

Written by a King's patient in 2015 who has been supported by the Integrated Respiratory Team

Example of good practice	Web link	Region	Key terms
H. The Delirium Recovery Programme West Hertfordshire Hospitals NHS Foundation Trust	http://www.westhertshospitals.nhs.uk/newsandmedia/mediareleases/2015/october/dementia_services_rated_as_outstanding.asp	South of England	Dementia Integrated working Living at home

The Delirium Recovery Programme was an innovation to address the prevalence of delirium in acute hospitals, which can affect up to 60% of frail elderly. These patients often endure long admissions. Persisting behaviour and cognitive symptoms, especially at night, can cause concerns and difficulties regarding discharge back to a person's home. As a consequence of limited options available to support discharge, a high proportion of these patients go directly to residential placement from hospital. The programme offers 21 days of intervention designed to provide patients with the opportunity to return home with 24 hours live in care. Tailor made care plans are produced with the patient to optimise the cognitive recovery process focusing on normal routine and engagement activities within their familiar home environment. Decision making happens throughout the programme including the patient, their family and the integrated physical and mental health and social care team. The programme has the opportunity to reduce costs by reducing length of stay to the acute Trust, but the most financial gains realised relate to avoided placement in residential care. The scheme cost £217,004, with comparative care costs estimated at £506,532, producing a full year net cost benefit of £225,648.

NHS England

Example of good practice	Web link	Region	Key terms
I. The Occupational Health Physiotherapy Fitness for Work Derbyshire Community health services NHS Foundation Trust	https://www.england.nhs.uk/challengeprizes/about/winners/winners-1415/fitness/	Midlands and East of England	Fitness for work

This initiative won the NHS England Rehabilitation Innovation Challenge award in 2015. The initiative focuses on getting people assessed quickly and providing them with the tools and treatments to recover. Since its inception, the scheme, costing £48,000 to operate has saved the Trust almost £250,000 in sickness absence costs.

Example of good practice	Web link	Region	Key terms
J. Health coaching initiative West Suffolk NHS Foundation Trust	http://www.fabnhsstuff.net/2015/07/02/innovative-new-programme-boost-patients-health/	South of England	Long term conditions Self-management

Health coaching initiative

People with long-term conditions are being given extra support to change their behaviour, manage their own care more successfully and improve their quality of life thanks to a new health coaching initiative at West Suffolk Hospital.

Senior physiotherapists, both qualified as accredited health coaching trainers as part of a regional initiative spearheaded by Health Education East of England. Over the coming 12 months, they will train 200 of their fellow West Suffolk clinicians in health coaching, giving them the right skills to motivate people to put their own health first and manage their conditions with more independence and confidence. The newly-trained clinicians will use their everyday contact with patients, such as outpatient appointments or follow up visits, to offer guidance and help them identify and fulfil meaningful personal goals. This could be anything from giving up smoking so that they can see their family grow up to increasing their fitness so that they can walk to the park to play with their grandchildren.

The initiative comes in response to statistics which show that patients with long term conditions account for 64% of all hospital outpatient appointments, 70% of bed days and 70% of total health and social care spend.

It is hoped the scheme will help tackle this trend by reducing readmissions, length of stay and the need for further follow ups after discharge, as well as further improve the experience patients have of using NHS services.

Health coaching can have a big impact on individuals, increasing their confidence, motivation and self-sufficiency and improving their quality of life. This can also have knock on benefits for the NHS, as it reduces their reliance on health services and the need for repeat GP visits or hospital admissions.

Example of good practice	Web link	Region	Key terms
K. Most innovative student-driven digital tool	http://www.fabnhsstuff.net/2015/08/13/go-with-the-flow-wearable-smartphone-app-that-senses-movement-and-related-physiological-processes/	All of England	Smart phone app Self-management Chronic pain

Most innovative student-driven digital tool

Go-with-the-flow – is a wearable Smartphone app that senses movement and related physiological processes (e.g., breathing) and transforms these signals into sound.

Smartphone sensors track movement and Arduino-based respiration chest belts detect breathing patterns related to anxiety.

'Go-with-the-flow' was created to support self-management of physical activity and consequently improved quality of life in people with chronic pain (CP). CP (pain that persists typically for at least 3 months) is a costly illness that accounts for 20% of the UK's total health expenditure and affects 7.8 million people in the UK. Clinical resources are unable to meet demand and many people do not get the help they need.

Daily physical activity is important for CP self-management: it protects against weakening and stiffness, increases confidence in physical capacity, and inhibits the spread of pain. Unfortunately, constant pain and associated emotional factors such as fear of movement and anticipated pain exacerbation due to activity, undermine adherence. Current physical rehabilitation technology does not address these critical psychological barriers nor or do existing CP apps that mainly track mood and physical activity and possibly plan for it.

To address this gap, a plethora of qualitative/ quantitative studies with physiotherapists and people with CP were conducted to understand needs, barriers and successful strategies. Next, a wearable Smartphone app called 'Go with the flow' was designed to implement and extend those strategies and to tailor strategies to individual needs and barriers. The solution was evaluated with 23 individuals in lab and home studies and also in two sessions at the hospital with patients and physiotherapists and people found the feedback rewarding and motivating and they felt it would be very useful for their daily activities.

The wearable device senses movement and related physiological processes (e.g., breathing) and transforms these signals into sound Smartphone sensors track movement and Arduino-based respiration chest belts detect breathing patterns related to anxiety. A tabard was designed to site all the components on the body.

Sonification feedback was designed to shift focus away from feared movement and pain onto an external pleasurable representation and provided a sense of control over their own movement. Sound was used to design an exercise space through anchor points, tailored by people to reflect their psychological and physical capabilities and set targets; sonification rules changed within this space giving body position and movement information. Alterations to sonification increased awareness of protective movement (e.g., asymmetric positions meant played only in one ear). Our studies indicated that increased body movement awareness increased self-efficacy and confidence. Tailoring feedback to people's psychological and physical capability, allowing setting of targets and rewarding even small movements increased motivation and perceived value of movement.

This work is innovative in addressing not only the physical, but also and mainly the unique psychological and emotional aspects of CP during physical rehabilitation and support of self-management, through addressing concerns of both physiotherapists and people with CP. Additionally, the technology supports everyday function and skill acquisition for better quality of life as people have to set their own targets according to the needs of the day. This research has the potential to influence the national health service (NHS), mobile health, and gaming industries. It provides a new perspective at a critical time where the mobile health (projected at £16 billion by 2017; wearables at £48 billion by 2025) and gaming industries are seeing unprecedented growth. Timely and regular support through technology developed through this research can reduce physiotherapist visits, empower people to better self-manage hence return to work sooner, and reduce CP's economic burden. Continuous engagement with industry through presentations and meetings have ensured that this technology is viable and further has the potential to be used in other conditions where mobility is restricted such as wheelchair users, sports injuries, and the elderly.

NHS England

Example of good practice	Web link	Region	Key terms
L. Cumbria diabetes puts DESMOND on the international stage, Cumbria Partnership	http://www.fabnhsstuff.net/2015/11/12/cumbria-diabetes-puts-desmond-international-stage/	North of England	Diabetes Self-management

Cumbria diabetes puts DESMOND on the international stage

We are delighted to announce that Cumbria Partnership DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme has been shortlisted as one of the Teams of the Year in the international celebrating DESMOND Annual Awards.

The annual programme aims to reward excellence and share good practice across the international DESMOND community, which delivers structured education about Type 2 diabetes.

The lead GP for Diabetes in Cumbria said: "We are delighted that our team has been recognised for all their hard work which has made DESMOND in Cumbria the success that it has become. DESMOND is a fundamental element in the treatment pathway of Type 2 Diabetes , providing a high value intervention to support people to take control and self-manage. Our aim is to provide education to people 'at risk' of Diabetes and with a confirmed diagnosis, to support people in making informed choices. The importance of what we eat and how active we are, can be huge in terms of avoiding Type 2 Diabetes and also affects the treatment required for diabetes. We also recognise the importance of patient education in helping people with diabetes be more confident to be actively involved in decisions around their Diabetes'.

In Cumbria over 6000 people with Type 2 Diabetes have attended the nationally recognised "DESMOND" structured education programme since it was launched in the county in 2009.

Another 4000 people who were identified at risk of developing Type 2 Diabetes have also attended the DESMOND Walking Away programme.

The DESMOND director said: "The standards were once again extremely high and the quality of entries is a testament to all of the hard, dedicated and innovative work being carried out by DESMOND teams."

The winners will be revealed on Friday 13th November, the day before World Diabetes Day 2015.

NHS England

Example of good practice	Web link	Region	Key terms
M. The Nottingham Recovery College Nottinghamshire Healthcare NHS Foundation Trust	http://www.nottinghamshirehealthcare.nhs.uk/nottingham-recovery-college	Midlands and East of England	Mental health or physical health Self-management

The Nottingham Recovery College

Nottinghamshire Healthcare NHS Foundation Trust, opened its doors in May 2011, providing a range of courses to help people to develop their skills and understanding, identify their goals and ambitions and give them the confidence and support to access opportunities. The aims of the college is to: –

- Provide a base for recovery resources.
- Promote an educational and coaching model in supporting people to become experts in self-care on their recovery journey.
- Break down barriers between 'us' and 'them' by offering training sessions run for and by people with experience of mental health or physical health challenges and people with professional experience.

The college brings together two sets of expertise, professional and experience, in a non-stigmatising college environment with the same systems as other educational establishments. All of the courses provided at the college are designed to contribute towards wellbeing and recovery. People who share experiences of mental health or physical health challenges teach on the courses with the intention of inspiring hope and embodying principles of recovery. The courses are designed to put people back in control of their life, helping each person to identify goals and ambitions whilst giving the confidence, skills and support to access opportunities.

NHS England

Example of good practice	Web link	Region	Key terms
N. Round-the-clock healthcare thanks to digital innovations at Airedale Airedale NHSFT	http://www.fabnhsstuff.net/2015/02/20/round-the-clock-healthcare-thanks-to-digital-innovations-at-airedale/	North of England	Elderly people Telemedicine

Round-the-clock healthcare thanks to digital innovations at Airedale

The Airedale Partner's Vanguard Digital care is providing thousands of patients, including those living in rural locations and who may be in the last year of their lives, with the reassurance of round-the-clock care, whenever their need it.

Residents living in around 200 care homes across the country are linked up to a Telehealth Hub, at Airedale Hospital, staffed 24 hours, seven days a week by highly skilled nurses who specialise in acute care.

They can have a face-to-face consultation via a video link, from the comfort of their own home, with a consultant on hand if needed – or just some friendly advice and support. It means they avoid making stressful and costly trips to hospital and the service provides vital medical support for care home staff out of hours.

Our findings are that for the nursing and residential homes using this technology:-image

- Hospital admissions dropped by 37%
- Use of A&E dropped by 45%.

Telemedicine is also used to support around 100 patients with long term conditions such as COPD, heart failure, complex diabetes in their own homes. There is evidence that amongst this group, this has resulted in:-

- A 45% drop in hospital admissions
- A 60% fall in A&E attendances
- A 50% reduction in overall bed days

This technology helps provide more care for residents at home or in their care home. This is what our patients, their relatives and the nursing home staff prefer and so it's been down to us to change the way we provide our specialist care to meet their needs

NHS England

Example of good practice	Web link	Region	Key terms
O. Health Coaching East of England	https://eoeleadership.hee.nhs.uk/Health_Coaching_Training_Programmes	Midlands and East of England	Self-management

Health Coaching

Health Coaching is a formal approach to behaviour change conversation that has been launched and adopted in the East of England supported by Health Education East of England. The approach enables clinicians to have conversations with their patients that are empowering and shared to motivate patients to self-manage, improve patient experience and satisfaction, support organisations to deliver effective long term conditions strategies and create clinical champions for shared decision making.

The Senior Community Physiotherapist, Cambridgeshire Community Services NHS Trust explained, "I used to create a dependency with my patients, where I depended on them to need me and hoped that they would want me to solve their problems. Big caseloads, slow turn over and feeling drained. Now, facilitate to move the responsibility back to the client/patient and support their awareness in their own potential and I have smaller caseload, higher turnover and feel energised and excited about the future".

NHS England

Example of good practice	Web link	Region	Key terms
P. The Early Intervention Team (EIT) West Suffolk Hospital West Suffolk NHS Foundation Trust	http://www.wsh.nhs.uk/AboutUs/News/NewsArticles2013/Specialistteamexpandedtohelpolderpatientsreturnhome.aspx	South of England	Early intervention Living at home Trans-agency working

The Early Intervention Team (EIT).

The EIT is a specialist team which sees health and social care staff work together to help older patients to return home from West Suffolk Hospital more quickly has been expanded.

The Early Intervention Team (EIT), which assesses older patients and plans for their discharge, has been expanded to cover seven days a week with the help of £400,000 in transformation funding from West Suffolk Clinical Commissioning Group.

From Monday 18 November, its working hours also increased, with the team now working from 8.30am to 9pm on weekdays and 10am to 5pm at weekends and on bank holidays.

The EIT work closely together to assess older people within the ED and short stay unit and develop a discharge plan which puts the right support in place to allow patients to return home after they have received their treatment and are clinically fit. The integrated service provides a 'one-stop shop' where patients can be assessed for all of their equipment, mobility and care needs along with help with domestic activities and follow up services in the community.

The integrated therapies manager at the hospital, said: "The expansion of the Early Intervention Team is great news for our patients, who will benefit from a joined up approach across organisations which meets their own individual needs.

"By recruiting seven extra staff, including the new team lead and extending our hours, we are able to further improve the service we offer to older people by making sure they receive high quality, targeted and safe care which reduces their length of stay.

"By planning comprehensively for their discharge and making sure all of the support they may need is in place before they leave the hospital, we are also helping them get home more quickly."

As part of the project, Age UK Suffolk's 'Welcome Home Service' has expanded its hours of work. The service works from the hospital to help support more vulnerable patients returning home following discharge. Once at home, they can assess the situation, provide advice and offer individually tailored support by helping them to regain daily living skills such as cooking, shopping and laundry. This gives the older person confidence and helps prevent readmission to hospital.

The director of services with Age UK Suffolk, said "The service will make a real impact on early supported discharges and reductions in readmissions. Sometimes the simplest things can make the biggest difference – knowing you have the support you need, especially if you live alone, can give you the confidence to return home sooner."

NHS England

Example of good practice	Web link	Region	Key terms
Q. Westminster Integrated Gangs Unit Central and North West London NHS Foundation Trust Westminster Child and Adolescent Mental Health Service team	http://rcni.com/newsroom/nurse-awards/supporting-mental-health-needs-inner-city-gang-members-28706	London	Mental health Young people Trans-agency working

Westminster Integrated Gangs Unit

A clinical nurse specialist working in the Westminster Integrated Gangs Unit (IGU) and with Central and North West London (CNWL) NHS Foundation Trust's Westminster Child and Adolescent Mental Health Service team aims to help improve the health of socially stigmatised, deprived young people associated with gangs. The team works with social services, the police and community protection.

The clinical nurse specialist was brought in following a Home Office Report in 2011, which showed significant unmet mental health needs in young people involved in gangs.

Some have developmental problems such as learning disabilities, as well as health needs and substance misuse. Furthermore, they often have longstanding behavioural problems. Some are known to traditional Child and Adolescent Mental Health Services (CAMHS) services. Some have a history of attention deficit hyperactivity disorder (ADHD).

The clinical nurse specialist says: 'Anxiety is a major problem. These young people need to carry knives from one part of the borough to another. And their high levels of substance misuse can escalate into untreated psychosis.'

Young girls carry particular risk factors – 20 per cent in Westminster are involved in gangs. They are at very high risk of sexual exploitation and, subsequently, self-harming. Substance misuse may also be a factor. Both male and female young people are at risk of kidnapping through gang activity.

The clinical nurse specialist also helps families affected by gang culture. 'There is a lot of parental stress from raising these children,' she says.

The clinical nurse specialist receives referrals from five key workers and has built links with youth offending teams and probation services. She does in-reach work in prisons to engage young people and build relationships before release back in to the community.

It can be a challenge to get young people with chaotic lifestyles to engage. The clinical nurse specialist often uses their physical health needs as a way in to a mental health assessment. A key strategy has been to strengthen pathways with A&E units and other hospital and community services. The clinical nurse specialist liaises with workers from Red Thread – a youth violence intervention project that covers A&E and trauma units.

NHS England

The clinical nurse specialist has to be highly flexible. She meets young people on the streets, in cafes, at home and in youth clubs. Patience is key. 'I don't have a Did not Attend list and I regularly get stood up at McDonalds, but I look at context and what it means. What is going on with that young person, their behaviour and lifestyle?' she explains.

'There are many challenges and it takes a lot of perseverance. When a young person is not engaging with the team we have to look at diverse alternatives. We might intervene when they are at school, or if they are in custody I go there and see if we can have a chat.

'Timing can be important. Some spiral further into crime, so there can be a dip before a breakthrough. There is a high level of violence around the transition from adolescence to adulthood, aged about 15 to 17, which carries on until they are 18 or 19.'

When the young person will not tolerate the clinical nurse specialist, she will try to go through their parents. This has been successful, but not being judgemental is crucial. 'I have had 80% acceptance from parents. It is very important that I'm not there to 'take their kids away'.

To help deal with the specific vulnerability of her young female clients, the clinical nurse specialist has developed links with a sexual health clinic at St Mary's Hospital in Paddington. 'There are significantly high levels of chlamydia among girls involved in gangs,' she says. 'And we look at the mental health impact of sexual exploitation, which can escalate very quickly into self-harm.' There are safety planning measures for girls at risk of sexual exploitation and kidnapping, and a mental health plan to help reduce self-blame and self-harm.

A vast majority – 80% – of the young people are from a minority background, often first generation children.

'If we don't pay attention to culture and the impact that this has on the families we would be missing a huge chunk of potential positive interventions,' says the clinical nurse specialist.

There is a major conflict between young people's values and their parent's values, which tend to be conservative.

'Parents find it difficult to discuss and understand the concept of their children having sex before marriage, and there is real stigma around that,' says the clinical nurse specialist. 'Much of my work is about repairing relationships in these families.'

She adds that language is also important. 'I never use the word gang in my work – it is about peer relationships.'

The clinical nurse specialist knows that they are not reaching all the young people who need help. 'We can only help those who become known to the police or social services,' she explains. 'Others may be at risk of exploitation and engaged in high-risk behaviour, but are not yet proved to be committing crimes.'

However, her colleagues and partners say she has made real improvements to her clients' health – and lives.

The Acting Inspector of the Westminster Gangs Unit says the nurse input into their work has been 'highly beneficial'. He adds: 'She has worked with numerous gang members, many of whom have been subjected to highly traumatic experiences in their past. She is an integral part of our team.'

And her clinical supervisor, CNWL consultant child and adolescent psychiatrist, says the clinical nurse specialist's outstanding mental health nursing knowledge, skills and experience, coupled with her empathy and commitment, have secured her success in a difficult field.

NHS England

'The clinical nurse specialist is able to engage young people not primarily looking for help and are often initially dismissive of their need for professional intervention.' 'Her warm, enthusiastic and persuasive style enables these difficult, often inarticulate, youngsters to share and reflect on their general health and mental health needs, and the links with their behaviour. She never gives up on giving young people the chance to find positive solutions to their life dilemmas.'

Example of good practice	Web link	Region	Key terms
R. Building our leaders of the future Norfolk and Norwich University Hospitals Coaching and Management Solutions	http://www.fabnhsstuff.net/2015/02/14/building-our-leaders-of-the-future/	Midlands and East of England	Leadership Education

Norfolk and Norwich University Hospitals along with Coaching and Management Solutions has designed a leadership programme to develop our leaders for the future.

The course is now in its third year and has a great blend of lectures, simulation exercises, practical tasks and exposure to other organisations, commercial and private sector among them.

The course exposes the participants to an eclectic and exciting mix of learning: from orienteering experiences in Scotland, to learning about emotional intelligence and how to develop their own EI, to our existing leaders sharing experiences both good and bad of their own development, to seeing how NASA develops its approach to safety and the learning we can take from that. The participants spend time in other hospitals with their peers, seeing how those other organisations develop their people and establish their strategies and values. The participants undertake a project, jointly or individually, which supports the hospital in its ongoing improvement programme.

Overall the programme has been established to develop those with potential to lead the hospital through the future challenges. It's something we are proud of.

NHS England

Example of good practice	Web link	Region	Key terms
S. The Integrated Community Services (ICS) team Shropshire Community Health NHS Trust & Shropshire Council	http://www.shropscommunityhealth.nhs.uk/rte.asp?id=11181	South of England	Leadership Inter-disciplinary working

The Integrated Community Services (ICS) team was an innovative initiative developed and launched in partnership between Shropshire Community Health NHS Trust & Shropshire Council. They understood the importance of system leadership to drive meaningful change for patients and carers. They developed a "Purple" team, combining health and social care cultures and values (red and blue = purple). The ICS provides short term support after people are discharged from hospital to home, addressing specific care, reablement or rehabilitation requirements. The interdisciplinary integrated team consists of nurses, allied health professionals, social workers and voluntary sector colleagues. They support discharge from hospital and recovery to independence at home through a short-term targeted reablement programme. They also support temporary focussed reablement to maintain independence, avoiding a hospital stay. One of the teams key performance indicators is to reduce care dependency (social care carer calls) by 65% as a consequence of the service which the service continually achieves. Due to the success of this pilot in Shrewsbury, the service model and philosophy of care will be rolled out in North & South Shropshire from June 2015.

NHS England

Example of good practice	Web link	Region	Key terms
T. "Is there a pathway to recovery through care coordination?" Northumberland Tyne & Wear NHS Foundation Trust and Northumbria University	http://www.fabnhsstuff.net/2015/11/02/is-there-a-pathway-to-recovery-through-care-coordination/	North of England	Research Education Mental health

This NIHR funded emancipatory action research project had service user and carer (SU&C) engagement at its heart, reflected in the aims of the research to promote the critical evaluation of care coordination and recovery in mental health services.

Close links were forged between SU&C's, NHS professionals, Northumbria University academics, the NIHR Mental Health Network and the voluntary sector to support the research process. The dissemination phase was designed to engage NHS professionals and the researchers in critical dialogue (a series of workshops) about how care coordination practice, within the requirements of Refocusing CPA, could be changed based on the research findings, thus challenging traditional boundaries and perspectives. The highly relevant research findings continue to challenge and inform the improvement of (improve) mental health practice and pathways.

SU&C's shared responsibility for the whole research process, influencing the design of the research, collecting and analysing the data, and being accountable for the results, their interpretation and dissemination. This went far beyond a consultation model to a genuinely co-produced piece of work at all stages of the research. Many participants interviewed by the SU's and C's were empowered through the research process to reflect on their own recovery journey and consider how they might engage differently with their care coordinator in the future, thus promoting further user engagement in care coordination practice.

An accredited research training course supported the collaboration and team work which characterised the research at all stages. The project went beyond engagement to empowerment as the service user and carer researchers represented concerns and recommendations for service improvements with staff at all levels of the mental health service organisation. They are continuing to be active, a website presenting the findings (in part inactively) has been launched entitled Recovery and Wellbeing through Involvement in Research and Evaluation (RWIRE) see www.rwire.co.uk.

The practical and accessible nature of the findings have maintained all the stakeholders' interest, they are generating further research questions as part of a funded Clinical Research Group.

The researchers are now leading further evaluations of recently established services and have contributed to the NIHR Good Practice Guidance for the recruitment and involvement of service user and carer researchers which is being adopted nationally.

The research has promoted authority and credibility among service users and carers and these researchers have used the research findings to re-design services. Thus there has been an organisational impact as well as an observable effect on the lives of the service users and carers involved.

NHS England

Example of good practice	Web link	Region	Key terms
U. HIP QIP – Hip fracture quality improvement programme. Northumbria Healthcare NHS Foundation Trust	http://www.fabnhsstuff.net/2015/02/04/hip-qip-hip-fracture-quality-improvement-programme-northumbria-healthcare-nhs-foundation-trust/	North of England	Hip fracture Multidisciplinary working

HIP QIP – Hip fracture quality improvement programme. Northumbria Healthcare NHS Foundation Trust

176 hospitals admitted 70,000 patients with hip fracture last year. Ensuring safe, effective and equitable care for this large and often vulnerable group of patients remains a major public health issue. Overall one year mortality after hip fracture is high at around 30%. The pathway of care is complex. Survivors often face a life with decreased function, with 15% to 20% of people needing to change residence.

Our vision was to provide integrated care of the highest quality within a culture of continuous learning, innovation and development. Adopting the Institute of Medicine's definition of patient centred care, we aimed to transform key stages of the patient pathway. A large launch event with 140 participants ensured effective engagement from all stakeholders. We established a multidisciplinary audit framework (Quality Account) which outlined 12 deliberately ambitious standards.

We committed to measuring the right things, measuring well, measuring relentlessly and acting quickly. Our steering group met monthly to review progress against service goals. Multidisciplinary teams received weekly reports of their performance. Evidence suggested that prioritising additional nutrition for patients with hip fracture could lead to a reduction in our death rate. The surgical care bundle, pain block in A&E, surgery within 36 hrs and root cause analysis of every death were further measures adopted to reduce mortality. Training & support was provided to improve nutrition, pain management, information provision, early mobilisation and compassion at the point of care. Real time patient feedback was built into the local improvement strategy. Outcomes are reported to teams within 24 hrs of capture and also shared with patients, families and the public.

Results:

- Trust wide 30 day mortality has improved from 14.3% to 8% – a 44% reduction.
- Both our hospitals named as best in NHS for timely surgery in 2011 NHFD report – top 5 position maintained since then.
- 100% of medically fit patients are now mobilised by day 1 and 40% on the day 0 (previously 4%)
- 90% now receive a nerve pain block on admission – Previously 0%
- 97% of patients (n = 384) believed we did everything we could to effectively control pain.
- 90% of patients now receive additional feeding each day from dedicated nutritional assistants.
- Consistently excellent Patient Experience scores of above 95% across the domains of care that matter most to patients.

NHS England

HIP QIP transformed the quality of our care and brought issues of safety and clinical effectiveness into the work of improving patients' experience. Having staff authentically involved in driving service improvements alongside and through the eyes of patients gave us the best chance of rapid change. It has also enabled us to sustain and build on progress over three years, something that is notoriously difficult to achieve. 4 years on, we have significant improvements to share: our patients are now more likely to survive, have faster access to information, imaging, surgery, better pain management and early physiotherapy 7 days a week. We believe these results are fab and entirely replicable

Example of good practice	Web link	Region	Key terms
V. Elderly and dementia patients get creative, thanks to charity workshops Paper Birch Imperial College Healthcare Charity	http://www.fabnhsstuff.net/2015/11/29/craft-workshops-dementia-patients/	London	Elderly Dementia Art therapy

A series of artistic workshops have been held at Charing Cross Hospital aimed at elderly patients and those with dementia, run by creative team 'Paper Birch' and funded by Imperial College Healthcare Charity. Paper Birch's founders, ran a series of weekly workshops involving a mix of projects where patients are encouraged to use arts and crafts as a means of expression.

The workshops are designed to help engage patients and encourage greater mobility. The founders are Masters students at the Royal College of Art, and having experienced the impact dementia and memory loss through ageing has on people's lives, they were determined to bring their own skills into the healthcare environment.

The workshops ran for six weeks in the elderly rehabilitation centre; each week the workshop focused on a different art or craft format. Highlights included paper flower making, creation of a bunting display and clay modelling. Laura and Faith are trained by 'Arts 4 Dementia' to focus the workshops on stimulating activities which promote physical wellness and also encourage story-telling and communication between the group.

The analysis of each workshop would include a 'glow moment' noted by the founders and these would generally document the moment that the workshop made a noticeable difference for one of the participants. This is one example: Making with Clay 'After working with a patient for the previous two weeks I had begun to form a companionship and friendship with him. We chatted about the previous week and I asked how his wife and family were. He then agreed to come into the day room but explained how he didn't feel up to doing much of the activity. Soon after he was working clay with his hands, rolling it out using a wooden rolling pin and using his hands to feel and discuss the various textures of the clay leaves. This was a huge transformation from previous weeks when he had struggled to even pick up a glue stick. It was a very rewarding moment for both of us.'

The Chief of Service at the Unit said "Everyone on the ward has been so impressed with the work that Paper Birch have done. One of my SHOs has just commented on how the patients seem so much more motivated and happier after their art sessions. I am quite sure that this results in better engagement with all members of the multidisciplinary team and hence improves their rehab potential and reduces their length of stay."

News about the positive impact the workshops were having on the patients spread and the Charity's arts team were contacted by the elderly unit at Hammersmith Hospital. They had a patient who had been a sculptor and was soon to be going into a care home, she was often disorientated and confused The staff felt she would benefit from some creative interaction and after a very special one to one session with Faith, spending the time in deep concentration and thought, she was astonishingly more lucid and happy.

Example of good practice	Web link	Region	Key terms
W. Portsmouth Information, Advice and Support Service, The Stroke Association Communication Support Coordinator	https://www.stroke.org.uk/finding-support/portsmouth-communication-support	South of England	Trans-agency working

Via a coordinator, the service supports patients and families from acute hospitals to the community, ensuring a smooth transition and supporting the integration of health and social care. Individuals receive a:

- Named contact point on discharge and
- Personalised set of goals.

Referrals can be made from the individual/family or any other organisation or professional, although the majority come from the stroke unit at the acute trust to ensure people are picked up early. The service prevents crisis situations, such as carer breakdown, depression and financial hardship, which might have resulted in a readmission to hospital.

Example of good practice	Web link	Region	Key terms
X. Islington Reablement Service Islington Housing and Adult Social Services	http://www.nhs.uk/Services/Trusts/Services/DefaultView.aspx?id=83568	London	Physical health and mental health Multidisciplinary working

NHS England

The service supports complex discharges from hospital and prevents unnecessary readmissions by stabilising social situations and offering increased multidisciplinary support in the care management of the medically frail and mentally vulnerable in the community. The discharge process has been streamlined by having one person provide support in assessment, discharge planning and follow up home visits.

Once in the community; reducing duplication and using an integrated and responsive service to service users, the service supports patients with physical and mental health needs.

Example of good practice	Web link	Region	Key terms
Y. Transition Therapy Team Solent NHS Trust	http://www.solent.nhs.uk/service-info.asp?id=58&utype=1	South of England	Transition

Moving from the supported environment of children's services to adult services is a recognised period of stress for young people and carers. During this transition period young people often struggle to navigate adult services and become disengaged from managing their complex health and social needs. The Transition Therapy Service is specifically designed to support young people with physical disability who are moving on from children's services. The service ensures on-going contact over sequential transitions, with the aim of helping young people develop the skills needed to manage more of their health care needs. The vision is to support disabled young people to become empowered adults. Consisting of a part-time Occupational Therapist and Physiotherapist this service supports over 70 young people to successfully:

- Access education and training service
- Avoid unnecessary inpatient admissions
- Facilitate interagency working

Reduce the requirement for repeat consultant and GP appointments

Reduce consultant and GP appointments.

NHS England

Example of good practice	Web link	Region	Key terms
Z. "Snowden@Home" Snowden at Home Early Supported Discharge Team Solent NHS Trust	NHS (2014c) Rehabilitation, Reablement and Recovery Quality Guidance Document. Wessex Strategic Clinical Networks. Retrieved from http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/	South of England	Stroke Early supported discharge Long term conditions Multidisciplinary working

This service is adapted the stroke early supported discharge model to support the step up (avoiding admissions from the community) and step down (facilitating discharge) rehabilitation of patients with long term neurological conditions. The service operates 8am to 8pm, 7 days each week, providing up to 4 rehabilitation and reablement visits per day. The service has proved to be of significant benefit for both service users and their carers and demonstrates positive patient outcomes and high levels of satisfaction.

The role of family and carers is acknowledged as being very important to the success of the service. The collection of clinical, performance, patient satisfaction and activity measures indicates that the service can provide effective rehabilitation which would otherwise have necessitated an increased in-patient stay.

Example of good practice	Web link	Region	Key terms
AA. The Hospital Assessment and Discharge Team Torbay and Southern Devon Health and Care NHS Trust	NHS (2014c) Rehabilitation, Reablement and Recovery Quality Guidance Document. Wessex Strategic Clinical Networks. Retrieved from http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/	South of England	Reduced length of stay Multidisciplinary working

NHS England

The team is multidisciplinary, based within Torbay Hospital and facilitates safe, timely discharges. The team works in very close partnership with South Devon Health Care Trust (SDHCT) and integrated zone teams across Torbay providing:

- Greater flexibility in discharge planning
- Responsiveness
- High risk handover minimisation
- An increase in continuity of care
- Specialist support for complex patients

This has been achieved through:

- Discharge coordinator role
- Specialisation of the team
- Screening of less complex patient referrals to the zone teams who best know their patients

A key achievement has been measured in reduction of time spent in hospital and positive user feedback.

NHS England

Example of good practice	Web link	Region	Key terms
BB. Portsmouth Support at Home Service British Red Cross	http://www.redcross.org.uk/About-us/Media-centre/Press-releases/2015/July/Portsmouth-support-at-home-service	South of England	Trans-agency working Living at home

Co-located at Queen Alexandra Hospital, this service smooths the process of settling back into a routine at home following hospital admittance, enabling people to regain their confidence and maximise their long term independence. The service is tailored to people's expressed needs, and may include listening and befriending, assistance with or preparation of food, shopping, transport to hospital and GP appointments, collection of medication, medical equipment loan and strengthening links to social and cultural opportunities.

Example of good practice	Web link	Region	Key terms
CC. TQ at Home Southern Health NHS Foundation Trust	http://www.southernhealth.nhs.uk/knowledge/clinical-services/tqtwentyone/tq-at-home/	South of England	Reduced length of stay Living at home Emotional and practical support

TQ at Home work with local hospitals and community hospitals to bridge the gap so people can leave hospital sooner and provides emotional as well as practical support for patients who would otherwise have a delayed discharge whilst waiting for the commencement of social care packages. The service is individualised for each patient. From January 2014 to July 2014 the service saved 639 bed days.

NHS England

Example of good practice	Web link	Region	Key terms
DD. Falling in love with technology, innovation and good practice, to reduce falls in older people	https://www.england.nhs.uk/challengeprizes/about/winners/winners-1314/technology/	Midlands and East of England	Falls Reduced waiting times Older people

The Community Falls Prevention Programme, led by Anglian Community Enterprise in Essex, has reduced waiting times and helped to cut falls-related ambulance call-outs for over 65s in the area by more than half.

Traditional medical assessments for falls prevention look at the different health problems that might lead to a vulnerable older person falling, such as balance and strength. But under the new model, teams made up of specialist technical instructors, qualified therapists, charities and local volunteers also carry out a detailed assessment of the social factors that might contribute to falls, such as an older person's environment, footwear or even shopping habits.

Organisational changes mean the service has been able to go from a monthly throughput of 80 referrals, and a three-month waiting list, to 400 referrals a month, with an average response time of five days. Adoption of mobile and paper-light systems has further improved efficiency and freed up more time for face-to-face contact with patients.

The number of ambulance call-outs per month for patients over 65 fell from 272 to 116 in the space of eighteen months.

Example of good practice	Web link	Region	Key terms
EE. FAST (Fast Assessment Start Treatment)	https://www.england.nhs.uk/challengeprizes/about/winners/winners-1314/fast/	South of England	Pelvic floor Self-management

Poole Hospital NHS Foundation Trust has piloted a new model of conservative care for patients with pelvic floor issues that is cutting waiting times and improving outcomes.

The approach is based on shorter assessments for patients, soon after referral, with immediate treatment, rather than a three to five month wait for a longer, more in-depth assessment. Patients are given tailored treatment (mostly self-help) at their first clinic appointment.

The team in Poole has found that patients are responsive to a self-help approach and are more motivated to be compliant with correct exercises and fluid/ dietary alterations. As a result, 50% of patients required no further follow-up or treatment as there was sufficient improvement with self-care. This, in turn, has freed up more time for follow-up appointments, increasing throughout.

NHS England

The new approach required only a few changes to implement in Poole and the team believes it can easily be adapted to suit local needs in other areas.

Patient Outcomes

- Clinic throughput increased by 50% with only seven additional staff hours per week.
- 27% of patients were seen in 21 days or less with the vast majority of the rest seen within 4-6 weeks, compared to previous waiting times of 3-5 months.
- 50% required attendance at only a single FAST appointment.

Value for Money

Previously all patients referred would have had an average of five hours with a specialist physiotherapist, which would have cost in the region of £150. With 50% of cases now requiring just half an hour to an hour of physiotherapist time, costs of care per episode have been dramatically reduced.

Example of good practice	Web link	Region	Key terms
FF. Leicester Open Mind in partnership with Fit for Work Leicestershire Partnership NHS Trust	https://www.england.nhs.uk/challengeprizes/about/winners/winners-1415/open-mind/	Midlands and East of England	Musculoskeletal Physical health and mental health Fit for work Self-management

Dealing with, and recovering from, long-term pain can be hugely challenging. Expert support, though, is key in helping people suffering with musculoskeletal injuries to cope and, ultimately, to return to rewarding and productive work.

The Leicestershire Partnership NHS Trust's rehabilitation team has explored the use of Cognitive Therapy and Mindfulness techniques – a mind-body approach to wellbeing – to try to help individuals overcome their physical, social and mental barriers, such as depression and anxiety.

The team worked closely with the Fit for Work Team at the Department of Work and Pensions (DWP), which has developed recognised expertise in helping people with chronic pain, before developing their Open Mind programme.

NHS England

People are referred to the service either by a GP or the team of Open Mind therapists. Through their own case manager, they are offered a programme of interventions such as pain management and group cognitive behavioural therapy, as well as support services from a range of allied health professionals including physiotherapists and occupational therapists.

Key patient benefits

- Empowers individuals to shape their own bespoke recovery package.
- Reduces fear, improves mood and quality of life.
- Speeds rehabilitation and reduces length of time off work.

Value for money

- The Health and Safety Executive estimate around 8.8 million work days are lost due to musculoskeletal conditions.

A large part of the rehabilitation programme is delivered in more cost effective community settings.

Anticipated reductions in prescription costs.

Example of good practice	Web link	Region	Key terms
GG. My Health tools Kirklees	http://www.northkirkleesccg.nhs.uk/news/my-health-tools-launches-in-kirklees/	North of England	Technology Self-management Long term conditions

My Health Tools supports people living in Kirklees to manage the impact of their long term health condition through practical information, tools and skills.

1 in 4 people in Kirklees live with some sort of long term condition such as diabetes, asthma and long term pain. Managing a long term condition can be challenging, but with the right help and support, it is possible to learn to self-manage a condition and lead a better quality of life.

My Health Tools has been designed by and for local people, and will support them to better manage their needs, monitor their condition and help them to feel more in control. It provides access to a wealth of trustworthy information and resources giving people the more choices and the opportunity to access extra support.

NHS England

My Health Tools aims to help people make the changes they want, and improve their lives whilst living with a long term health condition. It can help people to:

- Feel in control of their lives while living with their health condition
- Increase their confidence to better manage their health condition
- Be inspired with many new ideas about how to best manage their health condition
- Access support and skills that meet their needs

My Health Tools helps people to take day-to-day control of their well-being. Underpinned by proven Cognitive Behavioural Therapy (CBT) techniques, My Health Tools encourages behavioural change by supporting users to achieve measurable goals. It takes a 'whole-person' approach that promotes independent decision-making – and users can also engage with a circle of formal and informal support.

My Heath Tools is being rolled out by Kirklees Council's Public Health Directorate, working with the Greater Huddersfield and North Kirklees Clinical Commissioning Groups (CCGs). It has been built by Kirklees Council-owned technology developer, Looking Local. Long-term health care professionals have also contributed to its development.

Example of good practice	Web link	Region	Key terms
HH. Examples of measuring outcome Advice on which outcomes to use, in order to assess good rehabilitation outcomes for patients	NHS (2014c) Rehabilitation, Reablement and Recovery Quality Guidance Document. Wessex Strategic Clinical Networks. Retrieved from http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/	South of England	Measurement of outcomes

System measures

Data on system measures could include:

- Delayed discharges
- 30 day readmissions
- Inpatient average length of stay (LOS)

NHS England

Process measures

Data on process measures could include:

- Evidence of completion and provision of personalised care plan on discharge
- Contact details of a named professional provided in the care plan
- Areas of patient need covered in care plan (e.g. health, social, psychological)
- Clinical outcome measure completed in hospital to establish baseline and recorded in care plan
- Elective patients being admitted with an anticipatory care plan Ideally, data should be analysed at hospital ward level so that areas of good practice could be highlighted and shared.

Quality outcome Measures

Data on quality outcome measures could include:

- Individualised ward level patient/carer/family experience post discharge
- Experience can be captured post discharge through survey/have your say event/focus group

Patients being able to remain in their own homes (links to NHS Outcome Framework indicator 3.6i and Adult Social Care Outcomes Framework indicator 2B – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation /reablement services)

NHS England

Example of good practice	Web link	Region	Key terms
II. HCPC (2014) Health and care Professions Council: Continuing Professional Development audit report.	http://www.hpc-uk.org/publications/reports/index.asp?id=907	National	Education CPD

The standards say that a registrant must:

- Maintain a continuous, up-to-date and accurate record of their CPD activities;
- Demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
- Seek to ensure that their CPD has contributed to the quality of their practice and service delivery;

Seek to ensure that their CPD benefits the service user; and 5. upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

Example of good practice	Web link	Region	Key terms
JJ. General Medical Council (GMC) (2012) Continuing professional development: guidance for all doctors. Advise that:	http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp	National	Education CPD

The topics covered within this document include:

- How doctors should plan, carry out and evaluate their CPD activities
- The importance of taking account of the needs of patients and of the healthcare team when doctors consider their own learning needs
- How doctors should reflect on the Good Medical Practice domains when evaluating their CPD needs
- The relationship between CPD and revalidation
- The use of appraisal, job planning and personal development plans in managing CPD and how to record CPD activities

The responsibilities of others, such as employers and Colleges, in supporting doctors' CPD

NHS England

Example of good practice	Web link	Region	Key terms
KK. Royal College of Nursing (RCN) (2014) RCN Factsheet: Continuing Professional Development (CPD) for nurses working in the United Kingdom (UK).	http://www.rcn.org.uk/development/learning/accreditation	National	Education CPD

In 2013 the Nursing and Midwifery Council launched a public consultation to review how nurses maintain their registration and re-register. In the future, this process will be called 'revalidation'. The new revalidation model will require that nurses undertake at least 40 hours of CPD every three years, up from the current minimum of 35 hours. In addition, half of this requirement (20 hours) will have to be committed to 'participatory' learning activities, such as seminars, learning workshops, shadowing other colleagues, etc. This system is due to go online in December 2015.

Example of good practice	Web link	Region	Key terms
LL. Big White Wall	https://www.bigwhitewall.com/landing-pages/landingv3.aspx?ReturnUrl=%2f#.VnQo8k8rhMs	National	Mental health Self-management

A safe online community of people who are anxious, down or not coping who support and help each other by sharing what's troubling them, guided by trained professionals.

Available 24/7, Big White Wall is completely anonymous so you can express yourself freely and openly. Professionally trained Wall Guides ensure the safety and anonymity of all members.

Big White Wall is available free in many areas of the UK via the NHS, employers, and universities. It is also free to all UK serving personnel, veterans, and their families.

One in four adults will experience some kind of mental health problem in the course of a year and the World Health Organization predicts depression will become the biggest cause of disability by 2020. Big White Wall provides an online service that members can turn to for support in managing their care, with access to clinicians, carers and each other. The service has attracted over 20,000 members who have benefited from quick access to help, guidance and individual live therapy over a secure link. It is now available to almost a quarter of the adult population through the NHS and other private and public sector organisations who have signed up to provide it to their employees. Almost three-quarters of respondents to an internal review said they had talked about something for the first time on Big White Wall, 80% were able to self-manage their condition as a result, and 95% said it helped them feel better.

NHS England

Example of good practice	Web link	Region	Key terms
MM. Leeds Care Record	http://www.leedscarerecord.org/	North of England	Technology Information sharing

As one of 14 integration pioneers, Leeds, in partnership with local communities, is using technology as a key enabler to develop new models of care that shift care closer to the home. Based on engagement with the citizen, in collaboration with the local Neighbourhood Network Schemes and two small and medium-sized enterprises, Leeds is using technology with a small cohort of elderly frail patients. They are assessing the benefit that community and informal care networks can have in the co-design of technological solutions in three key areas:

My Care/Support Network: Tools to help citizens capture information and documents and share these across networks of professionals, families and carers – improving exercise, diet and access to services.

Time and Care Budget Banking: Tools to help manage time-banking and personal care budgets, enabling the transfer of high volumes of low-level care from professional to community provision.

Civic Enterprise User Driven App Factory: A platform to enable new businesses/groups to develop apps for citizens, as well as to link citizens to professionals, using the person-centred care technologies.

They aim to use this technology to reduce isolation by improving coordination and communication. It is also envisaged that this approach will improve wider outcomes, such as reducing time away from work for carers. Going forward, the intended result is the creation of a secure, scalable communication, collaboration and information-sharing platform for Leeds, focused on citizens' needs and seamless integration with the Leeds Care Record.

NHS England

Example of good practice	Web link	Region	Key terms
NN. The COPD checklist project NHS Redbridge CCG University College London Partners Health Analytics	http://www.innovationunit.org/our-projects/projects/empowering-people-copd-manage-their-condition	London	Respiratory medicine Self-management

Chronic obstructive pulmonary disease (COPD) affects 1 million people in the UK and costs the NHS £491 million a year, much of that expenditure incurred in secondary care. COPD exacerbations account for over a million bed-days a year in England. Patients living with COPD want to be active partners in the management of their condition and appreciate the value of personalised information. When given the right support, they are keen to take recommended self-management steps and engage with clinicians to demand and create better care. The COPD checklist project, developed by NHS Redbridge CCG, University College London Partners and Health Analytics, tested the impact of providing COPD patients with personalised information on their condition and the level of quality they should expect to receive in their care, the performance of their local primary and secondary care providers, together with information on care costs. It used a traffic-light system indicating where each patient's care was (or was not) meeting expected NICE standards of access and quality.

NHS England

Example of good practice	Web link	Region	Key terms
OO. Identifying the economic value of the Keiro Service Pathway (2015) North East and Cumbria Academic Health Science Network	http://www.keirogroup.co.uk/independent-report-highlights-benefits-keiro-model-better-client-outcomes-and-substantial-reductions	North of England	Transagency working Neurological conditions Physical health and mental health

Keiro provides an integrated care pathway, encompassing a public/private/third sector partnership approach to rehabilitation, housing, leisure, information and educational services to enable people with neurological conditions and other complex care needs to regain and retain their independence.

Keiro promoting physical and mental wellbeing by providing therapy and leisure facilities, including a gym staffed by trainers knowledgeable in managing people with neurological conditions and a hydrotherapy pool to rehabilitate injured muscles;

Keiro encourage patients to self-manage their condition, informing them of the expected trajectory of their condition and advise and support on how to manage changes in it:

Encouraging peer support;

Providing psychological and emotional support to patients, families and carers;

Facilitating third sector organisations as they support the patient, family and carers in many aspect of daily living including benefit claims, returning to work, advocacy, adult education programmes and tools to improve daily activities (e.g. telecare and telehealth equipment).

Future research is recommended

Strengths = the model could be applied to other health conditions requiring rehabilitation intervention

Limitations = limited evidence base, limited data available so far

NHS England

Example of good practice	Web link	Region	Key terms
PP. ICARES (integrated care service) Sandwell and West Birmingham Hospitals NHS Trust	http://www.swbh.nhs.uk/services/integrated-care-service-icares	Midlands and East of England	Long-term conditions Multidisciplinary working

ICARES is a service and an approach to managing adults with long term conditions irrespective of their diagnosis, location or age.

It includes a whole range of staff including nurses and therapists providing specialist community interventions which will:

- avoid unnecessary admissions to hospital
- help maintain health and well being
- improve independence and function

It is open 8am – 8pm, 7 days a week.

Who can receive ICARES?

Anyone 16+ years of age with a long term condition who has;

- A Sandwell GP or
- are receiving care services irrespective of GP or
- Live in a Sandwell care home irrespective of GP

There is open access to ICARES – anyone can refer at any time

The referral will be triaged by a clinician who will ring the patient and work with them to find out what their issues are at this point in time. A clinical decision will then be made with the patient, as to when a response will be provided. This will be based on the conversation and other information gathered from case notes and the referral.

- Urgent referrals, where an admission could be avoided, will be seen within 3 hours
- Patients who are highly complex and at risk of becoming urgent will be seen within 72 hours
- Those requiring rehabilitation will be seen within 15 days

NHS England

Example of good practice	Web link	Region	Key terms
QQ. Talk About Norfolk Community Health and Care NHS Trust	http://www.pearsonclinical.co.uk/Sitedownloads/shine-a-light/2015/case-studies/norfolk-talk-about-team.pdf	Midlands and East of England	Early intervention Children and young people Speech and language

The Norfolk Talk About Team was the winner of the Community Friendly Award at the 2015 Shine a Light Awards.

The Talk About project, now in its fourth year, sought to improve the communication skills of children initially aged three to five by skilling early-years practitioners and then later by working across all ages up until five. Ten specialist speech and language therapists (SLTs) worked with Norfolk County Council to run the first formalised training programme the department had run for early-years staff. Norfolk's children have scored below the national and regional averages on the Early Years Foundation Stage Profile (EYFSP), which summarises and describes children's attainment at the end of the Early Years Foundation Stage (EYFS), measures of language and communication over recent years. The importance of early language development on educational attainment was recognised by Norfolk County Council, particularly around upskilling early-years staff leading to the Every Child a Talker (ECAT) project being run. This resulted in accelerated progress for some children but much less impact on those at risk of speech and language delay. Talk About 1 was developed to impact these children and around half of Norfolk settings opted in. Initially launching in 2012 following a successful two-year bid, there have since been two one-year extensions. Talk About 2 focused on the areas with the highest need through more intense and personalised training following an audit of settings' needs. All settings used the Norfolk ECAT monitoring tool and very few chose not to opt in to this second round, usually with very good reason. Talk About 3 has a great emphasis on developing language in the home learning environment for those children's centres with the lowest outcomes despite settings' excellent work. Talk About 2 attracted many requests from those not targeted with the intervention and in response six core training courses are now being regularly delivered across the county during Talk About 3. Data has shown that the number of children at risk of delay across all four areas of communication has decreased significantly (around 10% in each area) from Spring 2013 (first set of ECAT data) to July 2014 (fourth set of data). Practitioners' confidence levels were also audited and showed significant change, with nearly 90% feeling confident or very confident across all areas questioned. The Talk About Team has been awarded the Community Friendly Award for their Talk About project being truly multi-disciplinary and systematic in its approach to using evidence.

NHS England

Example of good practice	Web link	Region	Key terms
RR. The frequent flier scheme Great Ormond Street Hospital for Children NHS Foundation Trust	http://www.gosh.nhs.uk/medical-information/clinical-specialties/cystic-fibrosis-information-parents-and-visitors/noticeboard/frequent-flyer-programme-ffp	London	Cystic fibrosis Children and young people Long-term conditions

The Frequent Flyer Programme manages the needs of children and young people with cystic fibrosis through an intensive home physiotherapy programme, dietary support and individually tailored exercise training at a local fitness facility. This has reduced the need for routine intravenous antibiotic treatment and hospital admissions. This 12-month intensive programme resulted in important improvements in clinical status, lung health and quality of life, along with substantial savings to the NHS.

Example of good practice	Web link	Region	Key terms
SS. Video for parents on postural management Lincolnshire Community Health Services NHS Trust Children's therapy team	http://www.fabnhsstuff.net/2016/01/13/setting-record-straight-postural-management	Midlands and East of England	Long-term conditions Children and young people

A new training video has been created by Lincolnshire Community Health Services NHS Trust (LCHS) Children's Therapy Team, to help highlight the importance of good postural management.

Parents will be fully supported when watching the training video by their physiotherapist or occupational therapist, due to the hard hitting message the video delivers.

The video, aimed at parents and carers, includes why postural management is so important, as well as highlighting some of the potential health complications if a child's body shape is not protected.

Postural Management describes the 24-hour physical management of a child who has a physical disability and limited independent movement; it's therefore all about protecting the child's body shape. Children who find it difficult to move, for example those with multiple disabilities – are most at risk of developing body shape distortions i.e. hip dislocations and twisting of the spine. This is because they sit and lie in limited positions and lack the ability to move freely and achieve a straight position.

The video will be used as a tool by the Children's Therapy Team to help inform and support families to make informed decisions about their child's postural management, so that they can become experts in their care.

NHS England

Example of good practice	Web link	Region	Key terms
TT. School-based service for children and young people with type 1 diabetes	https://www.england.nhs.uk/challengeprizes/winners-2015/type-1	London	Diabetes Children and young people

When Hillingdon Hospital found many young people were failing to attend their paediatric Type 1 clinics, they devised an innovative, yet simple, solution – take the clinics out into their local schools.

As a result, attendance has soared to 98%, patients are delighted and the reorganisation of the service has been completed at no extra cost, either to the NHS or the hospital.

By consulting parents, the hospital team discovered most appointments were being missed because parents did not feel they could afford to miss work or they did not want their children to miss too many lessons. The youngsters involved meanwhile, did not feel unwell, did not like being reminded of their condition and did not feel the need to see a doctor.

The new system has never been tried before in the UK. Now an outreach team consisting of a consultant, specialist nurse, dietitian and a psychologist visit six local schools to run the clinics, which are viable as long as a least four pupils with Type 1 diabetes can attend.

The team has noted that communication with their young patients has improved because they feel more relaxed at school, while awareness of diabetes-related issues has been promoted among welfare officers, school nurses and teachers.

Key patient benefits

- 98% attendance rate from 92 clinic episodes.
- Reduced incidence of hospital admission among school clinic patient cohort.
- Positive response from school welfare officer survey.
- 96% positive score in patient satisfaction survey.

Value for money

- Hospital clinic ‘Did Not Attend’ rate has fallen from 30% to almost zero.
- Significant savings from better self-management and reduced hospital admission.
- Wider economic benefit from reduction in missed school and work time.

Example of good practice	Web link	Region	Key terms
UU. Abertawe Bro Morgannwg University Health Board: Lymphoedema service	http://www.wales.nhs.uk/sitesplus/863/page/39315	Wales	Lymphoedema

ABM UHB runs a pioneering and award-winning Lymphoedema Service which helps to prevent or control the swelling up of arms, legs or any part of your body including head and neck.

Lymphoedema can be a debilitating and very unpleasant side-effect of the life-saving treatment offered to cancer patients, but with early intervention, it can be prevented or controlled.

The service has won many prestigious Lymphoedema team awards, including the Macmillan Team of the Year Award 2013, The CSP Team of the Year Award 2013 and CSP Award for CSP Delivering Quality and Demonstrating Impact Award 2013.

Services are provided across the health board with the base in Singleton Hospital, Swansea, a satellite clinic in Cimla Hospital, Neath and with collaborative working with Tenovus a clinic is held on the Tenovus Mobile Unit in Bridgend (Brewery fields) every week. We currently have more than 2500 on our caseload and have helped more than 5,000 patients since the service started in January 2001.

This service was originally funded by Macmillan and only people with a cancer diagnosis were able to access the service. This is because cancer treatment can lead to problems causing a build of fluid due to poor drainage of excess fluid. A common side effect of mastectomy for example, can be a swollen arm because the surgery can also remove lymph nodes, which are an important part of the lymphatic system.

Since 2005 all people who have swelling for other medical reasons are able to receive assistance on how to manage their life-long condition. The service is also working closely and in collaboration with Tissue Viability Nurse, District, and Dermatology Nurse Specialists to streamline care for those persons with complex lymphoedema and wounds.

Self-management is vital to control lymphoedema and simple techniques are used including a good skin care routine, moving your body, managing a healthy weight, wearing compression garments and doing self-massage. More intensive treatment may be required in severe and complex lymphoedema and these techniques include lymphatic drainage massage, compression bandages and controlled breathing.

As well as helping people who have lymphoedema to improve their quality of life, the service is also an excellent example of prudent health care in Wales.

For every £1 spent on lymphoedema treatments, it is estimated the NHS saves £100. That is because limbs which are greatly swollen can result in damaged skin and infections which necessitate hospital stays of at least five days.

Lymphoedema treatment can prevent this from happening thus empowering the person, supporting them to keep active and to maintain a healthier lifestyle.

NHS England

Example of good practice	Web link	Region	Key terms
VV. Breast radiation injury rehabilitation service Royal National Hospital for Rheumatic Diseases NHS Foundation Trust Barts Health NHS Trust Christie NHS Foundation Trust	http://www.rnhrd.nhs.uk/uploads/files/729/FINAL%20BCC%20BRIRS%20award%20261113.pdf	National	Multidisciplinary Cancer

The BRIRS is a highly specialised service for those experiencing pain from injury following radiotherapy for breast cancer. The condition is rare and cannot be reversed but when left untreated can lead to secondary complications that can result in significant deterioration in health. The risk factors that led to these injuries are well understood today and are now carefully avoided.

The BRIRS team brings together a multi-specialty, multi-disciplinary team including specialist clinicians in the fields of oncology, rheumatology, psychology, lymphoedema and pain as well as specialist nurses, occupational therapists, respiratory physicians and physiotherapists. Together the teams can provide long-term rehabilitation support for the complex healthcare needs of each individual patient.

A senior clinician explained "This is a great example of Trusts working together to best meet the needs of patients. Our partnership ensures patients can access a clinic closest to where they live and we can deliver the same high standards of care across the country."

An inpatient at the RNHRD and says "This dedicated rehabilitation service has been invaluable for me and others suffering similarly."

The Breast Radiation Injury Rehabilitation Service is available to anyone registered with a GP in England; patients can self-refer or be referred to the service by a health care professional.

Example of good practice	Web link	Region	Key terms
WW. Trauma East Manual of Operations and Procedures (TEMPO)	http://www.eoetraumanetwork.nhs.uk/clinicians/trauma-east-manual-of-procedures-and-operations	East of England	Major trauma Best practice Multidisciplinary working

The Trauma East Manual of Operations and Procedures (TEMPO) describe the approved processes, pathways and management of patients with suspected major trauma in the East of England.

TEMPO is intended for use by clinicians and those involved in the care of major trauma patients and aims to reflect current best practice. Devised by clinicians throughout the region, and using the concept of the Clinical Guidelines for Operations from the Ministry of Defence, this manual defines standards of care and pathways aimed at reducing morbidity and mortality, and helping patients survive major trauma.

The web link allows access to a series of documents which include the full current version and certain chapters / forms from the manual for download. Please note that Edition 2 of the TEMPO manual was released December 2014.

NHS England

Example of good practice	Web link	Region	Key terms
XX 3 Dimensions of care For Diabetes (3DFD)	http://www.kcl.ac.uk/ioppn/depts/pm/research/diabetes-and-psychiatry/3-dimensions-of-care-for-diabetes.aspx	London	Diabetes Long term conditions

Diabetes is a serious and growing problem. Diabetes UK estimates it costs the NHS £1 million per hour, a figure that's steadily increasing. A partnership between King's Health Partners, London Boroughs and community organisations has developed a model that will improve the quality of care for patients, and enable them to manage their conditions effectively.

People with diabetes can face a complex web of different health and social challenges, which are most effectively addressed with an integrated approach. For example, worries about housing or employment or psychological stress can prevent people managing their condition effectively, and the best treatment deals with all of these issues together.

3DFD is a patient-centred multidisciplinary service integrating psychological and social care with diabetes care which has demonstrated improved psychological, social and medical outcomes for patients with multi-morbidity, at risk of diabetes complications, in two of the most ethnically and socioeconomically diverse boroughs in the UK: Lambeth and Southwark. 3DFD comprises clinical psychologists, third-sector support workers and a consultant liaison psychiatrist, integrated into the diabetes teams across primary, community and secondary care. Interventions are tailored to needs and include social support, brief psychological interventions, psychiatric assessment, psychotropic medications and the systemic management of complex patients, integrating mind and body care and addressing health inequalities. The service receives an average of 300 referrals per year: over 1100 patients have been referred into the programme.

On referral, patients had a mean HbA1c of 96mmol/mol (SD 20.3) (10.9% (SD 1.9) DCCT) and reported a reduction in HbA1c of 17mmol/mol, highly significant in reducing the risk of diabetes complications: UKPDS has shown the reducing HbA1c by 10mmol/mol reduces risks of complications by up to 40%. Sixty percent of patients received a new diagnosis of a psychiatric disorder (with 60% depression, a very treatable condition), indicating significant unmet health need. In the year following the intervention, compared with the previous year, 3DFD patients had reductions in A&E attendances of 45%, hospital admissions of 43%, and bed-days of 22%. The service cost £190K for 2 boroughs, but saved £225K in one year (£850 per patient per year): this is a cumulative saving mainly based on the reduction in hospital admissions.

3DFD provides evidence that a multidisciplinary approach is effective and adds value in the management of complex comorbidity in diabetes, with improvements in the domains of psychological functioning, social functioning, biomedical well-being and the appropriate utilisation of health services.

NHS England

APPENDIX 7: QUICK REFERENCE GUIDE FOR THE ECONOMIC BENEFITS OF REHABILITATION

Patient group	Context	Impact
British defence rehabilitation		As a result of rehabilitation intervention, 92% of service personnel with traumatic brain injury were in community employment (supported, transitional and competitive) at four months after injury.[212] As a result of rehabilitation intervention, the amputee mobility predictor with prosthesis (AMP-Pro) functional mobility scores for 75% of both double and triple amputees were typical of an active adult or athlete, with 91% attaining at least a score typical of a community walker.[212]
Cancer	There are over 750,000 people of working age living with cancer in the UK. Almost 120,000 people of working age are diagnosed each year. In 2008 it was estimated that £5.3bn in productivity was lost due to cancer survivors not returning to work.[182]	For every £1 spent on orthotic services, £4 is saved, representing a saving of £400m to the NHS.[56] If half of breast cancer survivors who initially return to work, but then leave, were helped to remain in work the economy could save £30m every year.[41] Pilots of vocational rehabilitation show a significant improvement in employment status between referral and discharge for many of those who received an intervention. While 38% went from "not working" to "working" or from "sick leave" to "full work or modified work", 7.8% remained in work or remained in a modified role. The average cost per patient was £850 and it was estimated that this would be recouped in tax returns within three months of employment.[183] Preoperative pulmonary rehabilitation for lung cancer patients reduced their complication rate from 16% to 9%, and reduced their readmissions from 14% to 5%. This gave a cost saving of £244 per patient.[18]

NHS England

Patient group	Context	Impact
Children and young people	It is estimated that approximately 203,000 children aged 6 to 10 years in the UK have speech and language impairment and require speech and language therapy.[42]	In comparison with routine speech and language therapy, enhanced therapy is estimated to result in an additional 5,500 students achieving five or more GCSEs A*-C (or equivalent). The benefit of providing enhanced speech and language therapy for all children aged 6 to 10 who currently have speech and language impairment exceeds the cost of the therapy by £741.8m.[42]
Chronic obstructive pulmonary disease (COPD)	24m lost working days, costing £2.7m, are due to COPD.[199] NHS cost of providing care for people with COPD is almost £500m and more than half of this cost relates to hospital care.[199] COPD is the second largest cause of emergency admissions.[200] 1m bed-days in the UK each year are taken for people with COPD.[200]	Rehabilitation intervention can reduce readmission rates from 33% to 7%.[200] Using a rehabilitation health club model and early intervention for COPD, cardiovascular disease and those at risk of falling, South of Tyne and Wear increased rehabilitation places from 120 to 300 without additional funding.[52] "Refresh rehabilitation" in South of Tyne and Wear is for patients with long-term needs, ensuring access to rehabilitation intervention when they need it.[52]
Diabetes	Obese people are up to 80 times more likely to develop type 2 diabetes.[186] The cost to the NHS to heal one diabetic ulcer is £3,000-7,500. A lower limb amputation costs £65,000. The NHS spends £1 in every £150 on foot ulcers or amputations each year. Of 135 amputations performed per week, 80% are potentially avoidable.[10]	The provision of orthoses prevents ulcers and amputation. Physical activity has been shown to improve glycaemic control to levels comparable with pharmaceutical intervention, thus reducing prescribing costs, diabetic-related complications by 32% and diabetic-related mortality by 42%.[10] Non-medical prescribing by podiatrists can reduce the number of appointments in secondary care from weekly to 6-weekly.[191] Multidisciplinary footcare team intervention produces a 70% reduction in amputation rate, reduction in length of stay and annual savings of £0.5m to offset £120,000 annual costs.[188] An integrated amputee rehabilitation service (southeast London) reduced length of stay from 40 days to 22 days.[52]

NHS England

Patient group	Context	Impact
Generalist rehabilitation	The number of people living with arthritis is expected to increase by over 50% among people over 65 by 2030.[207] Malnutrition affects up to 3m people and is estimated to cost the economy £13m. Malnutrition may occur as a result of illness or from a variety of physiological and social co-factors. Malnutrition is associated with increased mortality and morbidity. Malnutrition is associated with greater frequency of hospital admissions and longer hospital stay. Malnutrition is associated with a greater number of GP visits.[208]	The Heart of England NHS Foundation Trust provided 7-day therapy services and saved £3,000 per month.[209] Sandwell and Birmingham NHS Trust established a 7-day community rehabilitation team which resulted in 93% admissions avoidance in terms of referrals of people who would have been taken to hospital. The service receives 10,000 referrals per year.[52] A 5-day reduction in length of stay from 15 days to 10 days[229] as a result of minimising malnutrition provides an annual saving of £266m.[55] Collaborative working by medicines management, dietetics and community nursing services reduced oral nutritional supplements expenditure in London from an annual increase of 8% to a projected 6% decrease in 2011/12. Incorporating cost avoidance, this equated to a £2m saving.[210]
Integration of services		Sandwell and West Birmingham NHS Trust redesigned its service with no extra commissioner investment. It provided a single point of access to a team of rehabilitation generalists and specialists, and a gateway to intermediate care (including therapy and care management) on discharge into the community. It found that "did not attend" and cancelled appointments reduced from an average of 48 to 18 per month.[52] Greenwich NHS Trust provided an integrated multidisciplinary 7-day joint emergency teams service. This reduced the hours of work for the community COPD service, found £900,000 savings for the domiciliary care budget and provided an immediate response to prevent hospital admission. The model was extended to the musculoskeletal service and pilots in diabetes and memory clinics were considered.[52]

NHS England

Patient group	Context	Impact
Learning disability	People with learning disability may be three times at risk of falling than the general population, and 40% have at least one fall in a 12-month period.[189, 190]	A falls service set up within an NHS community learning disabilities team resulted in improvement in 93% of cases, including a reduced number of falls.[46]
Mental health and dementia	Employment rates for people with a mental health condition range from 20% to 30%, depending on the condition. This compares with 77% for those who are well.[38] Mental health problems are now the most common reason for sickness absence in non-manual workers in the UK.[184] One-quarter of all UK sick certificates are for mental health problems, but the average time off is about twice as long as for other illnesses, so they account for 40% of total time certified.[184] The economic and social costs of mental health problems in England was £105bn in 2009/10. This took into account costs for health and social care, loss of output and human costs.[187] The overall economic impact of dementia in the UK is £26.3bn. Of this, £4.3bn is due to healthcare costs.[185] Falls are the most common reason for hospital admissions, and account for 14% of all admissions for people with dementia.[104] The average length of stay in hospital following a hip fracture is seven days. However, over 85% of dementia patients with this injury stay for up to 14 days and 34% for over a month. The extra cost is estimated as £5,950 per patient.[104] Annual healthcare costs of medically unexplained symptoms in the UK exceed £3.1 billion. Total costs are estimated to be £18 billion.[222]	A randomised controlled trial in The Netherlands compared a) two or three 10-30 minute sessions of rehabilitation with a GP with b) the usual GP care. At 2-year follow-up, median sickness absence was reduced from four weeks to zero.[188] A cluster randomised controlled trial in The Netherlands compared a) an activating intervention by an occupational physician for patients with an adjustment disorder with b) usual occupational healthcare. At 1-year follow-up, median time for return to work was reduced from 51 to 37 days.[184] Physiotherapy services for people with dementia have been identified as key in contributing to a cost saving of £6m a year, including reducing length of stay for patients with dementia.[49] Exercise can have a significant and positive impact on behavioural and psychological symptoms of dementia[47], improving cognitive function and mood, which can reduce the need for pharmacological intervention.[48]

NHS England

Patient group	Context	Impact
Musculoskeletal disorders	Musculoskeletal disorders account for up to one-third of all GP consultations.[192] Musculoskeletal disorders account for 8.3m working days lost and cost society £7.4bn.[193] One in four UK adults is affected by chronic musculoskeletal disorders.[11] Musculoskeletal disorders are given as a "cause" for 60% of people on long-term sick leave.[194] 22% of people on Incapacity Benefit (Employment Support Allowance) have musculoskeletal disorders.[195]	Supported self-management of musculoskeletal disorders leads to 35% reduction in referral to services.[11] Early, intense and frequent rehabilitation for total knee replacement and hip fracture reduces length of stay, postoperative complications and costs. It increases function and quality of life and reduces the rate of falls.[196] Self-referral reduced patient-related costs such as prescribing, X-rays and MRI.[157] Self-referral saved £25,000 per 100 population.[157] Self-referral costs 25% less than traditional GP referral. GP prompted self-referral costs 10% less per episode. Self-referral releases capacity in primary and secondary care.[58]
NHS staff	Workers absent for an average of 14 days, missing work through illness or injury, costs the NHS £1.7bn a year (33.4m additional working days per year = 14,900 staff).[211]	Reduction of absence of 1% would produce a productivity benefit of £9m.[218] Colchester Hospital University NHS Foundation Trust allowed staff with musculoskeletal disorders early access to rehabilitation. Thus, 53% of staff remained in work and 21% returned to work within eight days. Savings of £586,000 were realised over six months.[39] York Hospital NHS Foundation Trust provided early rehabilitation intervention for staff, finding a 40% reduction in long-term sickness with an investment of £160,000 and cost savings £1.2m per year.[38] Derbyshire Community Health Services NHS Foundation Trust (winner of Rehabilitation Innovation Challenge Prize 2015) provided a Fitness for Work programme. Staff were self-referred or referred by their manager. A £48,000 investment produced savings of £250,000 in sickness absence costs.[59]

NHS England

Patient group	Context	Impact
Neurorehabilitation	There are 10m people in the UK living with a neurological condition that has a significant impact on their lives. 2% of the UK population are disabled by their neurological condition. Over 8m people are affected by a neurological condition, but are able to manage their lives on a day-to-day basis. There is increased prevalence of neurological conditions in older people as some conditions particularly affect older people and others are lifelong conditions. Approximately 850,000 people in the UK care for someone with a neurological condition.[108]	Rehabilitation intervention reduced the need for continuing care, reducing overall costs particularly in more dependent patients.[43, 44] The average cost of rehabilitation for patients who are severely disabled (£41,488) is offset over a period of 156 days in 16.3 months.[45] Rehabilitation intervention reduces dependency with an average saving in the weekly cost of care of £243.[45].
Osteoporosis	180,000 fragility fractures each year in England and Wales occur as a result of osteoporosis.[197] Hip fracture is the commonest reason for admission to an orthopaedic ward (usually a fragility fracture).[198] The average age of a person with a hip fracture is 77.[198] The annual cost of medical and social care for people with hip fractures is £2bn.[198]	Early rehabilitation reduces bed-days from 8.3 to 4.6 days and would produce savings of £75m if rolled out across the NHS.[53] A&E falls teams can prevent potential admissions to hospital and create savings of £33m.[11]

NHS England

Patient group	Context	Impact
Stroke	An estimated 152,000 people have a stroke each year.[201] Approximately 27,000 people of working age suffer a stroke every year.[202] There are approximately 1.1m stroke survivors in the UK.[203] Stroke accounts for 240,456 inpatient episodes of care.[203] 76% of stroke survivors have physical deficits.[151] The UK annual health and social care costs to manage stroke and its consequences are £4.6bn.[204] Informal care costs and productivity losses due to mortality and morbidity contribute a further £1bn each, giving total costs of £6.6bn.[204]	Every £1 invested in low-intensity speech and language therapy is estimated to generate £2.3m in healthcare cost savings through the avoidance of chest infections.[42] A specialist vocational programme for stroke patients at West Park Hospital increased return to work from 25% to 50%.[205] The Keiro Service Pathway for community neurorehabilitation estimates a saving of £14.8m for a 40-bed facility over a 10-year period.[206] Intervention from the Northern Devon Healthcare Trust stroke therapy team reduced length of stay by 6 days from 22 days, saving £833,700. Its hospital readmission rates reduced from 65% to 3% through strengthened links with community nurses. 13% more patients returned home rather than to a care home, saving over £75,500 per person.[54]

NHS England

APPENDIX 8: EVIDENCE TO UNDERPIN THE TEN PRINCIPLES OF GOOD REHABILITATION

Evidence underpinning principle 1

Care Act[159]

Care and Support of Older People with Learning Disabilities[86]

Chronic Obstructive Pulmonary Disease: Quality Standard[148]

Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]

Guidelines for Pain Management Programmes[144]

Guideline on Pulmonary Rehabilitation[147]

Identifying the Economic Value of the Keiro Service Pathway[206]

Mandate to NHS England[31]

Models of service delivery for people with learning disabilities and behaviour challenges[89]

Musculoskeletal Rehabilitation[129]

National Clinical Guidelines for Stroke[213]

NHS Standard Contract for Spinal Cord Injuries[150]

NHS Outcomes Framework 2015/16[28]

National Service Framework (NSF) for Long Term Conditions (LTC)[6]

National Service Framework for Older People[7]

No Assumptions[83]

No Health without Mental Health[125]

Rehabilitative Palliative Care[136]

Physical Activity: Brief Advice for Adults in Primary Care[141]

Prolonged Disorders of Consciousness: National Clinical Guidelines[220]

Social Care of Older People with Complex Care Needs and Multiple Long-term Condition[111]

NHS England

Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222]

Supporting People with Dementia and their Carers[105]

The Five Year Forward View[19]

Whole-person care: Parity[126]

Evidence underpinning principle 2

Amputee & Prosthetic Rehabilitation: Standards & Guidelines[92]

Better Outcomes, Lower Costs: Implications for Health and Social Care Budgets of Investment in Housing Adaptations[214]

Cancer Rehabilitation[14]

Care Act[159]

Care and Support of Older People with Learning Disabilities[86]

Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]

Hard Truths: The Journey to Putting Patients First[20, 157]

High Quality Care for All: Lord Darzi[161]

House of Care[114]

Identifying the Economic Value of the Keiro Service Pathway[206]

Long-term Neurological Conditions: Management of the Interface between Neurology, Rehabilitation and Palliative Care[138]

Mandate to NHS England[31]

Medical Rehabilitation in 2012 and Beyond[137]

Multiple sclerosis in adults: Management[118]

National Consensus Standards for the Nursing Management of CF[103]

NHS Standard Contract for Spinal Cord Injuries[150]

National Service Framework for Older People[7]

Osteoarthritis: Quality Standard 87[132]

Patient Experience in Adult NHS Service[s76]

Person Centred Care 2020[82]

Prolonged Disorders of Consciousness: National Clinical Guidelines[220]

NHS England

Ready to Go?[167]
Rehabilitation, Reablement and Recovery: Quality guidance document[61]
Service User Experience in Adult Mental Health[9]
Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]
Stroke Rehabilitation: Long-term Rehabilitation after Stroke[16]
Supporting People with Dementia and their Carers[105]
The Five Year Forward View[19]
Trauma Programme of Care Pathfinder Project: Low Back Pain and Radicular Pain[130]
Whole-person care: Parity[126]

Evidence underpinning principle 3

Cancer Rehabilitation[14]
Care Act[159]
Care and Support of Older People with Learning Disabilities[86]
Development of Patient-centred Standards of Care for Rheumatoid Arthritis in Europe[134]
Diabetes in Adults[109]
Everyone Counts: Planning for Patients 2013/14[171]
Falls in Older People[113]
Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]
Hard Truths: The Journey to Putting Patients First[20, 157]
Helping people make informed choices about health and social care[215]
High Quality Care for All: Lord Darzi[161]
House of Care[114]
Identifying the Economic Value of the Keiro Service Pathway[206]
Long-term Neurological Conditions: Management of the Interface between Neurology, Rehabilitation and Palliative Care[138]
Mandate to NHS England[31]

NHS England

Marmot review[27]
National Clinical Guidelines for Stroke[213]
NSF for Long Term Conditions[6]
Parkinson's disease in over 20s: Diagnosis management[119]
Personalised Health and Care 2020[84]
Person Centred Care 2020[82]
Rehabilitation, Reablement and Recovery: Quality guidance document[61]
Rehabilitative Palliative Care[136]
Service User Experience in Adult Mental Health[9]
Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]
Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222.]
Standards of Practice and Code of Ethics1[54]
Stroke Rehabilitation: Long-term Rehabilitation after Stroke[16]
Supporting People to Live Well with Dementia[106]
Supporting People with Dementia and their Carer[s105]
The Five Year Forward View[19]
The Fundamental Standards[70]
Vocational Assessment and Rehabilitation after Acquired Brain Injur[y156]

Evidence underpinning principle 4

Cancer Rehabilitation[14]
Care Act[159]
Care and Support of Older People with Learning Disabilities[86]
Chronic Obstructive Pulmonary Disease: Quality Standard[148]
Diabetes in Adults[109]
Falls in Older People[113]
Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]
Guideline on Pulmonary Rehabilitation[147]
High Quality Care for All: Lord Darzi[161]

NHS England

House of Care[114]

Identifying the Economic Value of the Keiro Service Pathway[206]

Long-term Neurological Conditions: Management of the Interface between Neurology, Rehabilitation and Palliative Care[138]

Mandate to NHS England[31]

Marmot review[27]

Musculoskeletal Rehabilitation[129]

National Clinical Guidelines for Stroke[213]

National Consensus Standards for the Nursing Management of CF[103]

National Service Framework for Older People[7]

No Assumptions[83]

Osteoarthritis: Quality Standard 87[132]

Personalised Care and Support Planning Handbook[172]

Person Centred Care 2020[82]

Physical Activity: Brief Advice for Adults in Primary Care[141]

Rehabilitation, Reablement and Recovery: Quality guidance document[61]

Rehabilitative Palliative Care[136]

Rheumatoid arthritis: Quality Standard 33[133]

Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions[111]

Standards for the Clinical Care of Children and Adults with CF[100]

Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]

Standards of Care and Good Clinical Practice for the Physiotherapy Management of CF[101]

The Five Year Forward View[19]

The NHS Outcomes Framework 2015/16[28]

Transforming Participation in Health and Care[173]

NHS England

Evidence underpinning principle 5

Amputee & Prosthetic Rehabilitation: Standards & Guidelines[92]

Cancer Rehabilitation[14]

Chronic Obstructive Pulmonary Disease: Quality Standard[148]

Everyone Counts: Planning for Patients 2013/14[171]

Falls in Older People[113]

Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]

Identifying the Economic Value of the Keiro Service Pathway[206]

Mandate to NHS England[31]

Medical Rehabilitation in 2012 and Beyond[137]

Multiple sclerosis in adults: Management[118]

NSF for Long Term Conditions[6]

National Consensus Standards for the Nursing Management of CF[103]

National Service Framework for Older People[7]

Osteoarthritis: Quality Standard 87[132]

Patient Experience in Adult NHS Services[76]

Prolonged Disorders of Consciousness: National Clinical Guidelines[220]

Ready to Go?[167]

Rehabilitation, Reablement and Recovery: Quality guidance document[61]

Rehabilitative Palliative Care[136]

Service User Experience in Adult Mental Health[9]

Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]

Standards for the Clinical Care of Children and Adults with CF[100]

Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222]

The Five Year Forward View[19]

Whole-person care: Parity[126]

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Evidence underpinning principle 6

Amputee & Prosthetic Rehabilitation: Standards & Guidelines[92]

Cancer Rehabilitation[14]

Development of Patient-centred Standards of Care for Rheumatoid Arthritis in Europe[134]

Hard Truths: The Journey to Putting Patients First[20, 157]

Head Injury: Quality Standard 74[90]

Falls in Older People[113]

Francis report[64]

Guidelines for Pain Management Programmes[144]

High Quality Care for All: Lord Darzi[161]

House of Care[114]

Long-term Neurological Conditions: Management of the Interface between Neurology, Rehabilitation and Palliative Care[138]

Mandate to NHS England[31]

National Clinical Guidelines for Stroke[213]

No Health without Mental Health[125]

Osteoarthritis: Quality Standard 87[132]

Person Centred Care 2020[82]

Prolonged Disorders of Consciousness: National Clinical Guidelines[220]

Rehabilitation, Reablement and Recovery: Quality guidance document[61]

Rehabilitative Palliative Care[136]

Rose report[165]

Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions[111]

Specialist Neuro-rehabilitation Services: Providing for Patients with Complex Rehabilitation Needs[115]

Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]

Standards for the Clinical Care of Children and Adults with CF[100]

Standards of Care and Good Clinical Practice for the Physiotherapy Management of CF[101]

Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222]

Supporting People with Dementia and their Carers[105]

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The Fundamental Standards[70]

Whole-person care: Parity[126]

Your Guide to our Standards for Continuing Professional Development[181]

Evidence underpinning principle 7

Everyone Counts: Planning for Patients 2013/14[171]

Falls in Older People[113]

Francis report[64]

Hard Truths: The Journey to Putting Patients First[20, 157]

High Quality Care for All: Lord Darzi[161]

House of Care[114]

Identifying the Economic Value of the Keiro Service Pathway[206]

Long-term Neurological Conditions: Management of the Interface between Neurology, Rehabilitation and Palliative Care[138]

Mandate to NHS England[31]

Medical Rehabilitation in 2012 and Beyond[137]

National Clinical Guidelines for Stroke[213]

National Service Framework for Older People[7]

Patient-centred Standards of Care for Rheumatoid Arthritis in Europe[134]

Patient Experience in Adult NHS Services[76]

Personalised Health and Care 2020[84]

Ready to Go?[167]

Sentinel Stroke National Audit Programme[74]

Service User Experience in Adult Mental Health[9]

Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions[111]

Standards of Care and Good Clinical Practice for the Physiotherapy Management of CF[101]

Stroke Rehabilitation: Long-term Rehabilitation after Stroke[16]

Supporting People with Dementia and their Carers[105]

The Five Year Forward View[19]

NHS England

Evidence underpinning principle 8

Everyone Counts: Planning for Patients 2013/14[171]

Francis report[64]

Guidelines for Pain Management Programmes[144]

Hard Truths: The Journey to Putting Patients First[20, 157]

High Quality Care for All: Lord Darzi[161]

House of Care[114]

Identifying the Economic Value of the Keiro Service Pathway[206]

No Health without Mental Health[125]

Rehabilitative Palliative Care[136]

Rose report[165]

Standards for Rehabilitation Services Mapped on to the NSF for Long Term Conditions[16]

The Five Year Forward View[19]

Whole-person care: Parity[126]

Evidence underpinning principle 9

A Strategy to Develop the Capacity, Impact and Profile of Allied Health Professionals in Public Health 2015-2018[15]

Care Act[159]

Hard Truths: The Journey to Putting Patients First[20, 157]

Identifying the Economic Value of the Keiro Service Pathway[206]

Mandate to NHS England[31]

Medical Rehabilitation in 2012 and Beyond[137]

National Clinical Guidelines for Stroke[213]

National Consensus Standards for the Nursing Management of CF[103]

NHS Standard Contract for Spinal Cord Injuries[150]

Personalised Health and Care 2020[84]

NHS England

Prolonged Disorders of Consciousness: National Clinical Guidelines[220]
Sentinel Stroke National Audit Programme[74]
Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions[111]
Standards for Rehabilitation Services Mapped on to the NSF for LTCs[116]
Standards for the Clinical Care of Children and Adults with CF[100]
The Five Year Forward View[19]
Whole-person care: Parity[126]

Evidence underpinning principle 10

Amputee & Prosthetic Rehabilitation: Standards & Guidelines[92]
Cancer Rehabilitation[14]
Chronic Obstructive Pulmonary Disease: Quality Standard[148]
Evaluating patient-based outcome measures[216]
Everyone Counts: Planning for Patients 2013/14[171]
Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]
Hard Truths: The Journey to Putting Patients First[20, 157]
High Quality Care for All: Lord Darzi[161]
House of Care[114]
How do Quality Accounts Measure Up?[68]
Improving Outcomes and Supporting Transparency: A Public Health Outcomes Framework for England, 2013-2016[30]
"It's the duty of every doctor to get involved with research"[217]
National Consensus Standards for the Nursing Management of CF[103]
Nutritional Management of CF[102]
Personalised Health and Care 2020[84]
Prolonged Disorders of Consciousness: National Clinical Guidelines[220]
Social Care of Older People with Complex Care Needs and Multiple Long-term Conditions[111]
Standards for the Clinical Care of Children and Adults with CF[100]

Standards of Care and Good Clinical Practice for the Physiotherapy Management of CF[101]

Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222]

The Adult Social Care Outcomes Framework 2015/16[29]

The NHS Outcomes Framework 2015/16[28]

NHS England

APPENDIX 9: QUICK REFERENCE GUIDE FOR THE TEN PRINCIPLES MAPPED TO EVIDENCE

Principle	1	2	3	4	5	6	7	8	9	10
Evidence base										
A public health outcomes framework for England, 2013-2016[30]	✓	✓	✓	✓	✓	✓	✓	✓	✓	
A strategy to develop the capacity, impact and profile of allied health professionals in public health[15]	✓	✓	✓	✓	✓	✓	✓	✓		✓
Amputee & prosthetic rehabilitation standards & guidelines[92]	✓			✓			✓	✓	✓	
Better outcomes, lower costs: Implications for health and social care budgets of investment in housing adaptations[214]	✓		✓	✓	✓	✓	✓	✓	✓	✓
Cancer rehabilitation[14]	✓							✓	✓	
Care Act[159]					✓	✓	✓	✓		✓
Care and support of older people with learning disabilities[86]					✓	✓	✓	✓	✓	✓
Chronic obstructive pulmonary disease quality standard[148]		✓	✓			✓	✓		✓	
Diabetes in Adults[109]	✓	✓			✓	✓	✓	✓	✓	✓
Evaluating patient-based outcome measures[216]	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Everyone counts: planning for patients 2013/14[171]	✓	✓		✓		✓			✓	

NHS England

Principle	1	2	3	4	5	6	7	8	9	10
Falls in older people[113]	✓	✓						✓	✓	✓
Francis report[164]	✓	✓	✓	✓	✓				✓	✓
Fundamental standards[70]	✓	✓		✓	✓		✓	✓	✓	✓
Guidelines for pain management programmes[144]		✓	✓	✓	✓		✓		✓	✓
Guidance for commissioners of rehabilitation services for people with complex mental health needs[223]						✓	✓	✓	✓	
Guideline on pulmonary rehabilitation[147]		✓	✓		✓	✓	✓	✓	✓	✓
Hard truths: The journey to putting patients first[20, 157]	✓			✓	✓					
Head injury, quality standard 74[90]	✓	✓	✓	✓	✓		✓	✓		✓
Helping people make informed choices about health and social care[215]	✓	✓		✓	✓	✓	✓	✓	✓	✓
High quality care for all: Lord Darzi[161]	✓				✓				✓	
House of care[114]	✓				✓				✓	
How do quality accounts measure up?[68]	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Identifying the economic value of the Keiro Service Pathway[206]						✓				✓
Long-term neurological conditions: management of the interface between neurology, rehabilitation and palliative care[138]	✓				✓			✓	✓	✓
Mandate to NHS England[31]								✓		✓
Marmot review[27]	✓	✓	✓			✓	✓	✓	✓	✓

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Principle	1	2	3	4	5	6	7	8	9	10
Medical rehabilitation in 2012 and beyond[137]	✓		✓	✓		✓		✓		✓
Models of service delivery for people with learning disabilities and behaviour challenges[89]		✓	✓	✓	✓	✓	✓	✓	✓	✓
Multiple sclerosis in adults: Management[118]	✓		✓	✓		✓	✓	✓	✓	✓
Musculoskeletal rehabilitation[129]		✓	✓		✓	✓	✓	✓	✓	✓
National clinical guidelines for stroke[213]		✓			✓			✓		✓
National consensus standards for the nursing management of CF[103]	✓		✓			✓	✓	✓		
NHS outcomes framework 2015/16[28]		✓	✓		✓	✓	✓		✓	
NHS standard contract for spinal cord injuries[150]			✓	✓	✓	✓	✓	✓		✓
NSF long-term conditions[6]		✓		✓		✓	✓	✓	✓	✓
National service framework for older people[7]			✓			✓		✓	✓	✓
No assumptions[83]		✓	✓		✓	✓	✓		✓	✓
No health without mental health[125]		✓	✓	✓	✓		✓		✓	✓
Nutritional management of CF[102]	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Osteoarthritis: Quality standard 87[132]	✓		✓				✓	✓	✓	✓
Parkinson's disease in over 20s: Diagnosis management[119]	✓	✓		✓	✓	✓	✓	✓	✓	✓
Patient-centred standards of care for rheumatoid arthritis in Europe[133]	✓	✓		✓	✓			✓	✓	✓
Patient experience in adult NHS services[76]	✓		✓	✓		✓		✓	✓	✓
Personalised care and support planning handbook[172]	✓	✓	✓		✓	✓	✓	✓	✓	✓

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Personalised health and care 2020[84]	✓	✓		✓	✓	✓		✓		
Person centred care 2020[82]	✓				✓		✓	✓	✓	✓
Physical activity: adults in primary care[141]		✓	✓		✓	✓	✓	✓	✓	✓
Prolonged disorders of consciousness: National clinical guidelines[220]			✓	✓			✓	✓		
Ready to go?[167]	✓		✓	✓		✓	✓	✓	✓	✓
Rehabilitation, reablement and recovery: Quality guidance document[61]	✓							✓	✓	✓
Rehabilitative palliative care[136]		✓					✓		✓	✓
Rheumatoid arthritis, quality standard 33[133]	✓	✓	✓		✓	✓	✓	✓	✓	✓
Rose report[165]	✓	✓	✓	✓	✓		✓		✓	✓
Sentinel stroke national audit programme[74]	✓	✓	✓	✓	✓	✓		✓		✓
Service user experience in adult mental health[9]	✓			✓		✓		✓	✓	✓
Social care of older people with complex care needs and multiple long-term conditions[111]		✓	✓		✓			✓		
Specialist neuro-rehabilitation services: Providing for patients with complex rehabilitation needs[115]	✓	✓	✓	✓	✓		✓	✓	✓	✓
Standards for rehabilitation services mapped on to the NSF for LTCs[116]	✓						✓			✓
Standards for the clinical care of children and adults with CF[100]	✓	✓	✓				✓	✓		
Standards of care and good clinical practice for the physiotherapy management of CF[101]	✓	✓	✓		✓			✓	✓	

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Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People[222].		✓		✓			✓	✓	✓	
Standards of practice and code of ethics[154]	✓	✓		✓	✓	✓	✓	✓	✓	✓
Stroke rehabilitation: Long-term rehabilitation after stroke[16]	✓			✓	✓	✓		✓	✓	✓
Supporting people to live well with dementia[106]	✓	✓		✓	✓	✓	✓	✓	✓	✓
Supporting people with dementia and their carers[105]				✓	✓			✓	✓	✓
The adult social care outcomes framework 2015/16[29]	✓	✓	✓	✓	✓	✓	✓	✓	✓	
The five year forward view[19]						✓				✓
Transforming participation in health and care[173]	✓	✓	✓		✓	✓	✓	✓	✓	✓
Trauma programme of care pathfinder project: Low back pain and radicular pain[130]	✓		✓	✓	✓	✓	✓	✓	✓	✓
Vocational assessment and rehabilitation[156]	✓	✓		✓	✓	✓	✓	✓	✓	✓
Whole-person care: Parity[126]			✓	✓			✓			✓
Your guide to our standards for continuing professional development (HCPC)[181]	✓	✓	✓	✓	✓		✓	✓	✓	✓