REHAB ON TRACK

Community Rehabilitation Best Practice Standards

Northern Ireland

April 2023

Rehabilitation makes people's lives better. Many of those who would most benefit from rehabilitation, however, face barriers to accessing services. A panel of experts from across the UK developed these standards, to help change that.

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Introduction

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

The Health and Wellbeing 2026 - Delivering Together plan sets out a more personalised, preventative and integrated approach to health and social care, that takes account of social, physical, psychological and mental health needs. Covid has reinforced the message that we must do things differently. Traditional models of rehabilitation and workforce configuration based on a single condition and/or diagnosis are no longer appropriate, given the current context of an ageing population with increasingly complex needs including multiple long-term conditions (LTCs).

The Community Rehabilitation Alliance (CRA) identified the need for robust quality standards in community rehabilitation to be developed, to be used by everyone involved in commissioning, delivering and/or receiving community rehabilitation services.

Purpose

This guidance provides a number of recommendations and standards which have been systematically developed to guide the development, delivery and monitoring of high-quality patient centred rehabilitation. It will provide a basis from which community rehabilitation services can deliver high quality evidence based rehabilitation to their patients and populations and seek to decrease both local and regional variation.

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

- Lead to clearer pathways for people with disability
- Enable supported self-management and goal setting
- Streamline pathways by facilitating early supported discharge from hospitals and preventing avoidable re-admission
- Ensure care delivery within people's own homes and communities wherever possible

This audiences for this guidance include:

- Adults with physical, cognitive, communication, mental health emotional and/or social challenges as a result of a health condition who use community rehabilitation services
- Families and carers of community service users
- Clinicians and managers delivering community rehabilitation
- Policymakers, commissioners and providers of community rehabilitation services.
- Directors of Rehabilitation
- Rehabilitation networks

This document uses the terms 'clinician', 'director' and 'commissioner' to describe the people in health and care services involved in creating and delivering community rehabilitation services.

This document uses the word 'patient' to describe people using community rehabilitation services to address their needs. The use of the biopsychosocial model ensures that clinicians respect patients as individuals. It is expected that:

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

Definition of Community Rehabilitation

For the purposes of this guidance, community rehabilitation is defined as all rehabilitation delivered to a patient in any setting outside a hospital. This description includes all rehabilitation delivered by Health and Social Care Trusts and any rehabilitation provided in community hospitals or care homes. It is provided by a multidisciplinary team, to optimise function, social participation and improve health and includes:

- biopsychosocial assessment
- information provision
- patient activation (i.e.building knowledge, skills and confidence)
- shared decision making
- goal oriented interventions
- support for self-management
- opportunity for behaviour change

In addition, the multidisciplinary team:

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

Community rehabilitation services may span a wide range of services as shown in Figure 1.

Long Covid clinics	Pulmonary rehabilitation	Cardiac rehabilitation	Musculoskeletal rehabilitation	UCR/Virtual wards/ESD services	Amputee rehabilitation
Community physiotherapy	Community occupational therapy	Community speech & language therapy	Assistive technology services	Wheelchair services	Orthotics services
Prosthetics services	Adaptation & equipment	Community rehabilitation team	Community nurorehabilitation	Brain injury rehabilitation	Multiple sclerosis team
Early supported discharge team	Vocational rehabilitation service	Spasticity services	Hearing impaired services	Low vision rehab	Intermediate care
Specialist nursing homes	Community rehabilitation beds	Transitional care services	Reablement teams	District nursing services	Care management

Figure 1. To demonstrate the range of community rehabilitation services

Key Recommendations for Systems

To enable the delivery of high quality community rehabilitation services, it is recommended that the proposed Integrated Care System (ICS) in Northern Ireland should

1. Appoint a rehabilitation lead within the proposed Integrated Care System's Regional Group, and ensure that there is a strong voice for rehabilitation across the proposed, area, local and community groups.

2. Establish a local provider rehabilitation network to include, primary, secondary, tertiary health and social care, independent, third sector and local government providers.

3. Review existing rehabilitation services to remove silos of care and duplication of services.

4. Publish an annual report on rehabilitation.

October 2022

Community Rehabilitation Recommendations — Summary Standards

Recommendation	Patient	Clinician	Rehabilitation Lead	Network	Commissioner	Social Care Provider
1 **Referral processes are explicit, easy, efficient and equitable**	Knows how and when to get help, when in need of rehabilitation, either through GP or self-referral	Refers patients to the right services by using a rehabilitation directory of services	Provides a rehabilitation directory, and ensures equality of access and provision of services	Determines how referral pathways can best be distributed, and establishes information systems for social care	Ensures resources are appropriately focussed and inequalities of access are minimised by monitoring groups that are underserved	Refers patients using a rehabilitation directory, and supports people to navigate the rehabilitation pathways
2 **Rehabilitation interventions are timely, co-ordinated and prevent avoidable disability**	Gets seen by the right person at the right time, and knows who co-ordinates rehabilitation	Undertakes assessments, shares information across the network, and knows local resources	Recognises and manages care co-ordination, and delivers/monitors mandatory training	Develops referral systems, and ensures patients are seen in a timely, co-ordinated way	Ensures rehabilitation pathway is timely, efficient and effective for different patient groups	Receives and shares information about the co-ordinated care of patients
3 **Rehabilitation interventions meet patients' needs and are delivered in appropriate formats**	Knows they have the best rehabilitation option to suit them	Is trained to deliver evidence-based care and shares decision making with patients	Maps, develops and describes pathways for patients with different needs	Shares training resources and supports the implementation of best practice recommendations	Maps pathways, analyses local population needs, and designs community rehabilitation	Understands the rehabilitation options and supports patients in their decision making
4 **Rehabilitation pathways should meet needs and be delivered locally with access to specialist services**	Gets co-ordinated support for physical and mental health, and can access the equipment needed	Works with local services but refers to specialist services if needed to ensure the best outcomes	Ensures information can be shared and provides resources to be shared with patients	Ensures systems are integrated and care packages are joined up across the course of the disease	Commissions local and out-of-area services to meet patients' needs and optimise outcomes	Supports people to attend appointments and to obtain equipment
5 **Rehabilitation programmes should enable optimisation, self-management and review**	Has the information, equipment and support they need to look after their condition	Works independently with appropriate workload to support patients to maintain their independence	Manages staffing to deliver timely and effective rehabilitation	Develops supported self-management approaches and shares training resources	Commissions needs-led, integrated community rehabilitation services and flexible pathways	Supports patients to do the activities that are important and appropriate for them
6 **Rehabilitation services are well led, adequately resourced and linked to other services**	Helps record rehabilitation progress and goals, and can give feedback	Collects data including patient goals and service activity, and contributes to audits	Conducts audits and benchmarks services, and identifies service priorities	Helps design and develop services that address unmet needs, and enables sharing of information	Commissions the development of data collection and defines how success is evaluated	Supports patients to discuss their progress and to give feedback
7 **Rehabilitation services involve families**	Family members are made welcome and empowered as important parts of the rehabilitation process	Identifies patients relying on carers, and encourages families to take part and contribute to care	Develops pathways to support families and monitors their experience	Helps design services that meet the needs of families, friends and carers	Commissions services that support families of patients with disabling conditions	Keeps families informed about changes in function

Community Rehabilitation Standards — Full version

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
When I need rehabilitation — My GP can refer me — I can refer myself by contacting the service directly I know how to do this because — There is a service directory which tells me who and how to contact the service I know when to do this because — My health care practitioner has explained this to me	There is a rehabilitation directory which contains the information I need to refer a patient to the services they need. If I am co-ordinating the rehabilitation, I can provide the means for the patient to contact me directly. At discharge, I provide the patients with a written rehabilitation plan which includes — Self management advice — How to maintain or progress function — Contact details for any next steps in the rehabilitation journey — Triggers for review — Routes to review	I provide a directory of rehabilitation services. I ensure that information that specifies the self-referral pathway is easily available. I ensure rapid and skilled triage of patients at the point of entry. The clinicians I manage set their appointment times so that they can support patients to self-manage, including learning how and when to self-refer. I work within the rehabilitation network to ensure that the written and online material meets the needs of the local community. I work with the rehabilitation network and health and social care providers to ensure that when a patient who is receiving social care is referred for community rehabilitation the social care provider is informed. I ensure equity of access and provision. I monitor referrals to ensure that underserved populations are not neglected.	The rehabilitation network works with patients, carers and local communities as partners to determine how referral pathways can be disseminated effectively to those that may need to access rehabilitation services. The rehabilitation network establishes systems that ensure that when a patient who is receiving social care is referred for community rehabilitation the Health and Social Care Co-Ordinator is informed.	I have completed a joint strategic needs assessment for rehabilitation services identifying current inequalities in access (and outcomes and future potential demand). I ensure the commissioning process includes monitoring of underserved populations. I work with the network and local health care organisations to ensure that inequalities of access are progressively minimised. I use population health management information to understand the needs of the local population and therefore ensure resources are appropriately focussed.	I know how and when to make a referral to the community rehabilitation service. I am aware of the range of services available to people I care for through reference to the rehabilitation directory. I am informed when a community rehabilitation referral has been made. I know how and when to contact the rehabilitation service for a person I care for. I support people I care for to navigate the community rehabilitation pathway.

Recommendation 2

Rehabilitation interventions are timely, co-ordinated and prevent avoidable disability

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
When I am seen — It is by the right person. — It is at the right time. — Everyone I see has all the information from other services that they need I know who is responsible for co-ordinating my rehabilitation and how to contact them.	I can undertake a needs led, biopsychosocial assessment. I can work with other disciplines when this would benefit the patient. I can share information, including up-to-date investigation, medication and test results across the network easily. I am aware of local resources which may facilitate social prescribing and ongoing activity. I know who is responsible for each aspect in the rehabilitation prescription.	I recognise the importance and complexity of the care co-ordination role by allowing enough time to be allocated to this in peoples job plans. I deliver and monitor mandatory training in needs led assessment and the biopsychosocial model. I work to ensure that paperwork and IT systems support interdisciplinary and needs led approaches including with social care. I ensure that information can be shared between systems easily and effectively. I facilitate case management discussion. I ensure that all team members have a shared understanding of admission and discharge procedures. I recognise the critical contribution social services and care services make — to improving rehabilitation outcomes — to care co-ordination	The network involves multiple providers, including primary, secondary and tertiary care, physical and mental health, and health and social care providers working together to ensure patients are seen in a timely, and coordinated way. The networks engage with providers to ensure information sharing with appropriate governance. The network develops systems that ensure referrals and transfers of care are streamlined throughout the network. The network supports collaborative working practices. The network shares training opportunities and resources. The network is supported by both local health and social care leaders and providers and the community planning through the local councils, as well as the rehabilitation lead and commissioner.	I have walked the ‘rehabilitation pathway’ with all members of the rehabilitation network including patients, carers and local communities as partners to be sure it is timely, efficient and effective for different patient groups.	I am confident that the people I support receive the right service at the right time. Information is shared with me about the person I support; including up-to-date investigation, medication and test results. I feel confident sharing information about the person I support. I have the information I need to provide collaborative care. I know who is responsible for co-ordinating my client’s care, and how to contact them directly.

Recommendation 3

Rehabilitation interventions meet patient needs and are delivered in an appropriate format

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
I know I have the best rehabilitation for me because — I am given information about different rehabilitation options. — I can discuss these options with the healthcare professional. — I have time to consider the options. — I can choose the best option for me. — My choice of treatment is written down for me in a 'rehabilitation prescription' — I can choose different rehabilitation when needed.	I am trained in — patient activation — shared decision making — simple behaviour change techniques I deliver evidence-based care. I have the time and skills needed to support necessary change to help patients meet their goals. I co-produce rehabilitation prescription with patients. I share the rehabilitation prescription with relevant providers across the network. I can offer patients a menu of different options for their treatment.	I deliver and monitor mandatory face to face training in — patient activation — shared decision making — simple behaviour change techniques I work with commissioners, local clinicians and the rehabilitation network to map current pathways, identify service duplications and service gaps. I work with local clinicians and the rehabilitation network to develop clear pathways for patients with different needs, including those with multimorbidity, and with options for patients with different levels of activation. I work with local clinicians and the rehabilitation network to define and describe those pathways so that clinicians and patients can chose the best pathway for each individual. I ensure staff have time to provide information, undertake patient activation, and shared decision making, recognising that 'front-ending' clinical consultations will save time in the long term.	The network shares training resources in patient activation. The network shares training resources in shared decision making. The network supports the service to implement best practice recommendations and deliver evidence based rehabilitation. The network supports the integration of research into practice.	I work with the Rehabilitation Lead, local clinicians and the rehabilitation network to map current pathways, identify service duplications and service gaps. I have considered levels of patient activation when analysing local population needs and designing community rehabilitation. I have considered levels of patient activation as part of outcomes-based commissioning.	I have the information I need to understand the different rehabilitation options that are available to the person I support. I operate within a Multi-Disciplinary Team and understand the roles of the other team members. I can support people in their decision making around the rehabilitation that best meets their need. I have a copy of the rehabilitation prescription for the person I support and am confident to support its delivery. I have the time and skills to support people to engage in their rehabilitation.

Recommendation 4

Rehabilitation pathways should meet needs and be delivered locally with access to specialist services

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
I have co-ordinated support for both my physical and mental health needs. I am seen locally, where possible. When the service I need is not available locally, I am referred onto a specialist service. I am able to access the equipment I need and I am taught how to use and maintain it. I feel confident to progress my rehabilitation treatment programme as needed.	I know when and how to refer on, and can manage transitions between services effectively. I can work with other local services and with mental health teams in a timely and integrated way to ensure the best outcomes for patients. I can access advice from specialist services easily. I am able to refer on to specialist services when indicated. I am aware of and can provide advice about Trust services, third sector/community and voluntary and other services as well as specialist health services. I feel confident to progress/ adapt the person's rehabilitation treatment programme as needed. I have access to the resources to support people to progress their rehabilitation treatment programmes.	I ensure information can be shared, with appropriate governance, between different services and care providers. I provide multidisciplinary input to care homes. I provide the resources which allow patients to progress their rehabilitation including equipment provision , short telephone contacts, emails, texts, online support.	Within the rehabilitation network, specialist services work with place based services to ensure comprehensive care packages are joined up across the disease trajectory. Within the rehabilitation network, commissioners and providers work together to ensure integrated systems. Through the network, providers work collaboratively to manage patient needs.	I ensure that patients can have their needs met, by commissioning local services. I recognise that patients may benefit from working with two services over the same period to optimise outcomes. I ensure services including health care for the elderly and rehabilitation medicine services are delivered in care homes. Where local services cannot meet specialist needs I support 'provider collaboratives' and commission 'out of area' services. Where an individual has highly specialist needs I ensure that the pathways for commissioning these are clear. This also includes major housing adaptations, specialised equipment and assistive technology including wheelchair provision.	I support people to attend appointments. When equipment is needed I can — Obtain and arrange maintenance of equipment. — Ensure the clinician is trained appropriately to support people to use the equipment.

Recommendation 5

Rehabilitation Programmes should enable optimisation, self-management and review

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
I am helped to do things that are important to me. The support I receive seems useful to me. I have been told about other services that may be useful. I have been given the information I need. I know what I have to do to look after my condition. I know when to ask for help. If I need to be seen again, I know when this will be. I have the equipment I need and I know how to use it. I know how and when to ask for a review. I am confident I will be reviewed when I need it.	I have an appropriate case load, (that allows time to assess patient activation, undertake shared decision making, and goal setting with the patient, and support self-management). I have the autonomy to decide the most effective course of rehabilitation and I have the time to deliver the required interventions I am aware of diverse social and cultural needs, and am confident in providing effective support. I support patients to maintain their independence, and social roles, including work. I have the time to work with a patient to support their self-management. I am able to work with patients to agree a review date, or when they should self-refer.	I have the budget to ensure adequate staff numbers, and expertise to deliver timely and effective treatment. I deliver and monitor mandatory face to face training in supported self-management. The service I manage provides generic and condition specific structured education courses, both digital and face and face-including accessible psychological support (within the context of condition adjustment and condition management). I ensure the long term conditions register is maintained and patients are offered an annual review. I provide practice placements to support the ongoing workforce supply for effective rehabilitation programmes.	The rehabilitation network works co-operatively, including people with lived experience, to develop supported self-management approaches including health coaching, self-management education and peer support. The network shares training resources in supporting self-management. The network provides appropriate psychological support within a rehabilitation context and facilitate mental health care where needed (by onward referral) under a matched care and collaborative care approach. The network shares/provides training in best practice for the rehabilitation pathways and programmes provided in the system.	I commission needs led, integrated community rehabilitation services particularly focussing on — Integrated physical and mental health services — Integrated health and social care I commission specialist services with clear access pathways. I commission flexible pathways based on patient need, and outcomes focussed not level of intervention. I commission vocational rehabilitation services. I commission services that support self-management including health coaching, self-management education and peer support. I commission a long term conditions register which allows regular review of patients with complex disability. I work with local communities and councils to ensure accessibility for populations to support rehabilitation.	I support people who draw from services to do the activities that are important to them. I support people who draw from care to receive support that is appropriate for their social, occupational and cultural needs. I support people who draw from care to feel confident in requesting longer access to rehab if they need it. I know how and when to ask for a review for the person I support.

Recommendation 6

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

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

The patient	The clinician	The Service/ Rehabilitation Lead	The network	The commissioner	The Health and Social Care Co-ordinator
I have been asked to complete questionnaires that record my rehabilitation progress and goals. I have opportunities to discuss my progress towards my rehabilitation goals. Providing feedback is easy. I know how my feedback is used. I can see how feedback is used in 'you said, we did' communications.	I have regular clinical supervision, to support my role delivery. I collect data as part of my job plan, including PROMS, PREMS, patient goals and service activity. I am aware of audits and service evaluations running in my department. I am expected to contribute to audits, service evaluations and quality improvement initiatives. I understand where the data I collect is sent. I understand how the data I collect gets used because there is regular feedback. There is a blame free culture which allows me to acknowledge and learn from errors	I ensure the appropriate governance of the community rehabilitation service. I conduct audits and benchmark my services against similar services elsewhere. I identify service priorities and link, collate and review data to these. I ensure staff are aware of the data analysis and how this feeds into service design. I ensure that the information system is appropriate and sufficient to gather and review information on rehabilitation services in order to monitor quality and outcomes. I support a learning culture around compliments, complaints, adverse and serious incidents.	The rehabilitation network works with patients, carers and local communities as partners to help design services that address unmet need. The network links with other networks to support service development and design. The rehabilitation network provides mechanisms for sharing good practice and audit findings across the network.	I define the core data set and determinants of success on which to evaluate the service provision. I benchmark the rehabilitation services and commission for progressive improvement in patient access, experience and outcomes. I commission the development of data collection processes for underserved populations. I support services to apply for innovation funding. I support the development of data sets for rehabilitation that offer live feedback and comparisons with national systems.	I can support people drawing from services to access opportunities to discuss their progress towards their rehabilitation goals. I can support people who use services to feedback at appropriate points during their rehabilitation services. I am aware of different ways to feedback (verbally, in writing, online, through questionnaires).

Recommendation 7
Rehabilitation Services involve Families

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

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

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

Appendix

Appendix 1 — Expert Reference Group

An external reference group (ERG) for this work was appointed in 2021. Its members were identified by inviting member organisations of the Community Rehabilitation Alliance (CRA) to nominate individuals with relevant expertise. This ensured representation from a broad range of disciplines, working in a variety of settings, academic expertise and wide user representation, through the patient charities.

Its role included:

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

The ERG meet on four occasions:

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

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

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

Appendix 2 — Methodology

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

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

NHS Rehabilitation Commissioning Guidance for England

WHO Community Rehabilitation Guidance

NHS RightCare Community Rehabilitation Toolkit

The National Service Framework for Long-Term Conditions

BSRM Guidance on Specialist Community Rehabilitation

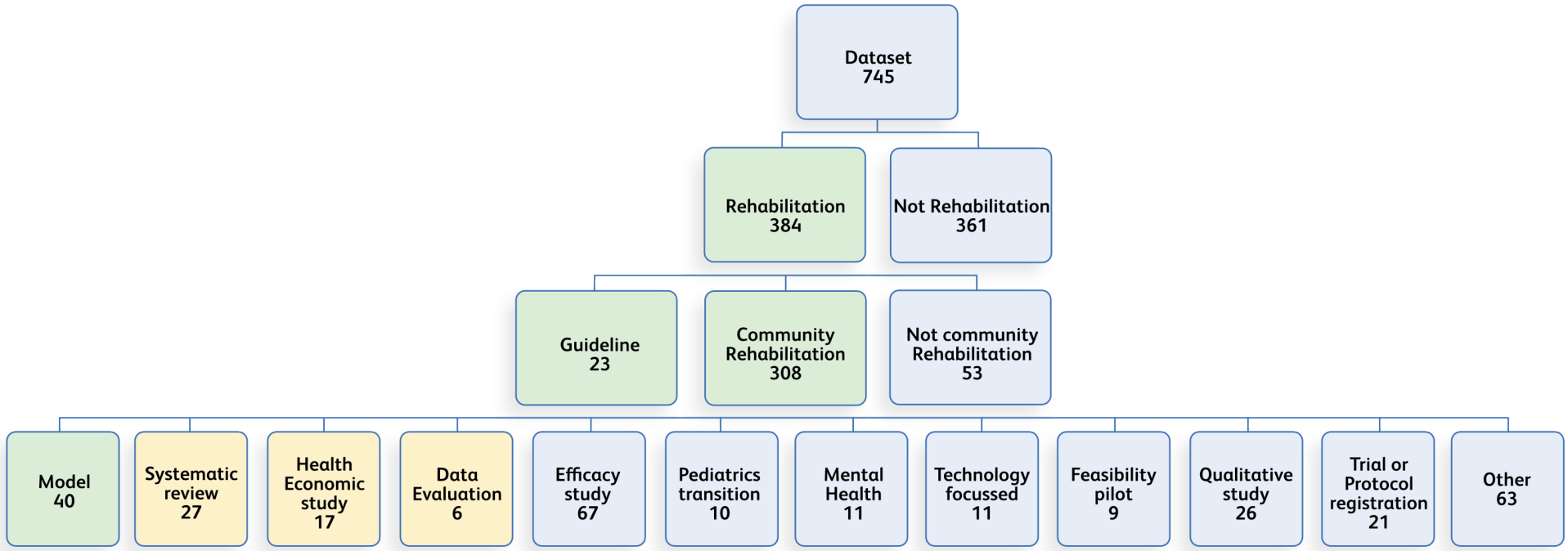
This created a framework for further analysis. A further 48 guidance publications were coded using the framework which was modified as the need arose. This followed a comprehensive database search using PubMed, EMBASE, Cochrane Library, PEDro and Psychlit to search clinical practice guidelines (CPG)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

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

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

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

Figure 4.2 PRISMA diagram of Discovery Search



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

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

Appendix 3 — Evidence Review for Recommendations

Recommendation 1

Referral processes are explicit, easy, efficient and equitable

	A Minimise health inequalities	B Population identification & segmentation	C Self referral	D Single point of access
Transforming Community Neurology 2016 https://www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf	✓	✓	✓	
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf				✓
WHO Rehabilitation 2030: A call for action 2017 https://www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action	✓			
NICE Cerebral Palsy in Adults [NG119] 2019 https://www.nice.org.uk/guidance/ng119			✓	✓
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf		✓		✓
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188				✓
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓	✓		
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97				✓
NICE Intermediate care including reablement [NG74] https://www.nice.org.uk/guidance/ng74			✓	✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93		✓		✓

King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓		✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 https://www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services	✓			
NICE Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186				✓
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206				✓
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓			✓
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf	✓	✓		
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22	✓			
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138	✓			
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211				✓
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓	✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf		✓		✓

NICE Shared decision making [NG197] 2021 https://www.nice.org.uk/guidance/ng197	✓			
Nuffield Shifting the balance of care [2017] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf		✓	✓	✓
Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162			✓	
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] https://www.nice.org.uk/guidance/ng27				✓

ERG commentary

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

Recommendation 2

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

Efficient and co-ordinated model of care	Biopsychosocial model	Care co-ordination	Clear patient journey	Early assessment	Sharing information
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 https://www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓		✓		
Transforming Community Neurology 2016 https://www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf		✓	✓		
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	✓
NICE Acute Coronary Syndromes [NG185] https://www.nice.org.uk/guidance/ng185			✓		
Canadian Stroke Best Practice Guidance 2020	✓	✓	✓		
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf	✓	✓			✓
BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 https://www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf			✓		
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188	✓	✓			
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓				✓

NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97		✓			
Fusco D, Ferrini A, Pasqualetti G, et al. Oncogeriatrics Group of the Italian Society of Gerontology, Geriatrics. Comprehensive geriatric assessment in older adults with cancer: Recommendations by the Italian Society of Geriatrics and Gerontology (SIGG). Eur J Clin Invest. 2021 Jan;51(1):e13347.	✓				
Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 https://www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓			
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93		✓			
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓		✓	
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 https://www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services			✓		
NICE Multimorbidity: clinical assessment and management [NG56] https://www.nice.org.uk/guidance/ng56		✓			
NICE Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186		✓			
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206	✓	✓			
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓	✓	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf					

NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22	✓	✓	✓	✓	✓
NICE Osteoarthritis: care and management [CG177] 2020 https://www.nice.org.uk/guidance/cg177	✓				
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138	✓	✓			
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86		✓			
NICE Rehabilitation after critical illness in adults [CG83] 2009 https://www.nice.org.uk/guidance/cg83	✓	✓			
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211	✓	✓			
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓		✓	✓	✓
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8			✓		
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf			✓		
NICE Shared decision making [NG197] 2021 https://www.nice.org.uk/guidance/ng197					✓
Nuffield Shifting the balance of care [2017] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf			✓		

NICE Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162		✓			
NICE Supporting adult carers [NG150] 2020 https://www.nice.org.uk/guidance/ng150			✓		
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] https://www.nice.org.uk/guidance/ng27			✓		
WHO Rehabilitation in health systems I Guideline 2017 https://www.who.int/publications/i/item/9789241549974			✓		

ERG Commentary

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

Recommendation 3

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

Accurate targeting of treatment	Goal oriented interventions	Information provision	Patient activation	Person centred	Rehab prescription/ plan	Shared decision making
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 https://www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓	✓		✓	✓	✓
Transforming Community Neurology 2016 https://www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf		✓		✓		
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	✓	✓
NICE Acute Coronary Syndromes [NG185] https://www.nice.org.uk/guidance/ng185		✓				
RACP Standards for the provision of rehabilitation medicine standards 2014 https://www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf		✓			✓	✓
Canadian Stroke Best Practice Guidance 2020 https://www.strokebestpractices.ca/	✓	✓	✓	✓	✓	✓
NICE Cerebral Palsy in Adults [NG119] 2019 https://www.nice.org.uk/guidance/ng119	✓	✓				
NICE Chronic heart failure in adults: diagnosis and management [NG106] https://www.nice.org.uk/guidance/ng106		✓			✓	
King's Fund: Co-ordinated care for people with complex chronic conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf			✓			

BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 https://www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf					✓	
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188		✓		✓	✓	✓
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓	✓	✓		✓	✓
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97		✓		✓		✓
NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 https://www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓		✓		
NICE Intermediate care including reablement {ng74] 2017 https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓		✓		✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93		✓		✓	✓	
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf				✓		✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 https://www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services				✓		
NICE Multimorbidity: clinical assessment and management [NG56] https://www.nice.org.uk/guidance/ng56	✓			✓	✓	✓
NICE Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186	✓	✓			✓	

NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206	✓	✓			✓	
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf		✓		✓	✓	
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf	✓	✓		✓	✓	✓
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22						
NICE Osteoarthritis: care and management [CG177] 2020 https://www.nice.org.uk/guidance/cg177		✓			✓	
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138		✓	✓	✓		✓
The King's Fund: patients as partners 2016 https://www.kingsfund.org.uk/publications/patients-partners						
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86		✓		✓		✓
NICE Rehabilitation after critical illness in adults [CG83] 2009 https://www.nice.org.uk/guidance/cg83	✓					
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211	✓	✓		✓	✓	✓
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓		✓		
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8				✓		

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

ERG Commentary

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

Recommendation 4

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

	Access to specialist services	Adequate and timely equipment	Integrated services - health & social care	Integrated services - other	Integrated services - physical & mental health	Locate care in familiar real life situations	Needs led
Transforming Community Neurology 2016 https://www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf				✓	✓	✓	✓
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓			✓	✓
NICE Acute Coronary Syndromes [NG185] https://www.nice.org.uk/guidance/ng185						✓	
Australian and New Zealand Pulmonary Rehabilitation Guidelines 2017 https://pubmed.ncbi.nlm.nih.gov/28339144/						✓	
RACP Standards for the Provision of Rehabilitation Medicine Services in the Ambulatory Setting 2017 https://www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf		✓					
WHO Rehabilitation 2030: A call for action 2017 https://www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action			✓	✓			✓
Canadian Stroke Best Practice Guidance 2020 https://www.strokebestpractices.ca/		✓				✓	
NICE Cerebral Palsy in Adults [NG119] 2019 https://www.nice.org.uk/guidance/ng119	✓	✓	✓		✓	✓	
NICE Chronic Heart Failure in Adults: diagnosis and management [NG106] 2018 https://www.nice.org.uk/guidance/ng106						✓	

King's Fund: Co-ordinated care for people with complex chronic conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf						✓	
BSRM Rehabilitation in the wake of Covid-19 2020 https://www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf		✓	✓	✓			✓
NICE Covid-19 rapid guideline:managing the long-term effects of Covid-19 [NG188] 2021 https://www.nice.org.uk/guidance/ng188	✓			✓	✓		
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf				✓			
Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 https://www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877					✓	✓	✓
Intermediate care including reablement [NG74] https://www.nice.org.uk/guidance/ng74	✓		✓	✓	✓	✓	
Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93	✓		✓				✓
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf			✓	✓		✓	✓
Mapping Local Rehabilitation and Intermediate Care Services A whole systems approach to understanding service capacity and planning change 2001 https://www.kingsfund.org.uk/publications/mapping-local-rehabilitation-and-intermediate-care-services				✓			
Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186		✓	✓				
Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206	✓	✓	✓			✓	

The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓		✓	✓	✓	✓	✓
Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22				✓			✓
Osteoarthritis: care and management [CG177] 2020 https://www.nice.org.uk/guidance/cg177		✓					
Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138	✓			✓	✓		✓
People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86		✓	✓				
Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211	✓	✓					
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf			✓	✓	✓	✓	✓
RACP Rehabilitation Medicine physicians delivering integrated care in the community 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8						✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway 2014 http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓	✓		✓			✓
Nuffield Shifting the balance of care [2017] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf	✓		✓				

Stroke rehabilitation in adults [CG162] 2013 **https://www.nice.org.uk/guidance/cg162**		✓	✓				
Supporting adult carers [NG150] 2020 https://www.nice.org.uk/guidance/ng150		✓					
Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] 2015 https://www.nice.org.uk/guidance/ng27			✓	✓			
WHO Rehabilitation in health systems I Guideline 2017 https://www.who.int/publications/i/item/9789241549974	✓	✓		✓			✓

ERG Commentary

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

Principle 5

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

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

NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 https://www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877		✓	
NICE Intermediate care including reablement {ng74] 2017 https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓		
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93		✓	
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓	✓
NICE Multimorbidity: clinical assessment and management [NG56] https://www.nice.org.uk/guidance/ng56		✓	
NICE Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186	✓	✓	
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206	✓	✓	✓
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf	✓		
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22	✓	✓	✓
NICE Osteoarthritis: care and management [CG177] 2020 https://www.nice.org.uk/guidance/cg177	✓	✓	✓
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138	✓		✓
The King's Fund: patients as partners 2016 https://www.kingsfund.org.uk/publications/patients-partners	✓		

NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86	✓		
NICE Rehabilitation after critical illness in adults [CG83] 2009 https://www.nice.org.uk/guidance/cg83		✓	
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211		✓	✓
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf		✓	✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders 2014 https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf			✓
Nuffield Shifting the balance of care [2017] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf			✓
NICE Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162		✓	
WHO Rehabilitation in health systems I Guideline 2017 https://www.who.int/publications/i/item/9789241549974	✓		

ERG Commentary

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

Recommendation 6

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

Table 1 – Data collection	Define core data	Link data to service priorities	Collect data	Support audit against quality standards	Support service evaluation	Support service evaluation
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 https://www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓		✓	✓	✓	
Transforming Community Neurology 2016 https://www.neural.org.uk/assets/pdfs/2016-06-transforming-community-neurology-transformation-guide.pdf	✓		✓	✓	✓	
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓	✓	✓	✓	✓
RACP Standards for the provision of rehabilitation medicine standards 2014 https://www.racp.edu.au/docs/default-source/advocacy-library/ambulatory-standards.pdf			✓	✓	✓	
WHO Rehabilitation 2030: A call for action 2017 https://www.who.int/publications/m/item/rehabilitation-2030-a-call-for-action	✓		✓	✓	✓	
Canadian Stroke Best Practice Guidance 2020			✓		✓	
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf			✓	✓	✓	
BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 https://www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf						
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188			✓		✓	

NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97			✓		✓	
Health Foundation Social care briefing https://www.health.org.uk/topics/social-care			✓		✓	
NICE Idiopathic pulmonary fibrosis in adults: diagnosis and management [CG 163] 2013 https://www.nice.org.uk/guidance/cg163/resources/idiopathic-pulmonary-fibrosis-in-adults-diagnosis-and-management-pdf-35109690087877			✓		✓	
NICE Intermediate care including reablement {ng74] 2017 https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓					
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93	✓	✓		✓		
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓			✓		
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf				✓		
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf						
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22						
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86						✓
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211			✓		✓	

Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓		✓	✓	✓	✓
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8		✓		✓		
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓					
Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders, 2014. https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓					
NICE Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162			✓		✓	
WHO Rehabilitation in health systems I Guideline 2017 https://www.who.int/publications/i/item/9789241549974	✓					

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

Canadian Stroke Best Practice Guidance 2020	✓	✓		✓	
BSRM Rehabilitation in the wake of Covid-19 - A phoenix from the ashes 2020 https://www.bsrm.org.uk/downloads/covid-19bsrmissue1-published-27-4-2020.pdf	✓				
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188	✓	✓			
King's Fund: Delivering better services for people with long term conditions 2013 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf	✓	✓	✓		
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97				✓	
NICE Intermediate care including reablement {ng74] 2017 https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓	✓	✓	✓
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf		✓		✓	
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf		✓		✓	
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf		✓		✓	
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22		✓		✓	
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138				✓	

NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86		✓		✓	
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211				✓	
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf	✓	✓	✓	✓	
RACP Rehabilitation medicine physicians delivering integrated care in the community 2018 https://www.racp.edu.au/docs/default-source/advocacy-library/rehabilitation-medicine-physicians-delivering-integrated-care-in-the-community.pdf?sfvrsn=8fb8091a_8	✓				
NHS England, South Safe, compassionate care for frail older people using an integrated care 2014 pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓		✓	✓	
NICE Shared decision making [NG197] 2021 https://www.nice.org.uk/guidance/ng197		✓	✓	✓	✓
Nuffield Shifting the balance of care [2017] https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf	✓		✓	✓	
NICE Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162				✓	
NICE Supporting adult carers [NG150] 2020 https://www.nice.org.uk/guidance/ng150		✓			
WHO Rehabilitation in health systems I Guideline 2017 https://www.who.int/publications/i/item/9789241549974	✓	✓	✓	✓	

ERG Commentary

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

Principle 7

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

	Carer support	Involve families where appropriate
CSP COVID-19 Rehabilitation Standards Community rehabilitation: physiotherapy service delivery 2021 https://www.csp.org.uk/system/files/publication_files/001745_Community%20Rehab%20Standards_A4_V7.pdf	✓	✓
BSRM Standards for specialist rehabilitation for community dwelling adults 2021 https://www.bsrm.org.uk/downloads/2021-v9.3-22-3-21-speccommunitystandards-summary-fortheweb-clean.pdf	✓	✓
NICE Acute Coronary Syndromes [NG185] https://www.nice.org.uk/guidance/ng185		✓
Canadian Stroke Best Practice Guidance 2020	✓	✓
NICE Cerebral Palsy in Adults [NG119] 2019 https://www.nice.org.uk/guidance/ng119		✓
NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 [NG188]2021 https://www.nice.org.uk/guidance/ng188		✓
NICE Dementia: assessment, management and support for people living with dementia and their carers [NG97] 2018 https://www.nice.org.uk/guidance/ng97	✓	
NICE Intermediate care including reablement {ng74] 2017 https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909	✓	✓
NICE Learning disabilities and behaviour that challenges: service design and delivery [NG 93] 2018 https://www.nice.org.uk/guidance/ng93	✓	✓
King's Fund Making our health and care systems fit for an ageing population 2014 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf	✓	✓

NICE Multimorbidity: clinical assessment and management [NG56] https://www.nice.org.uk/guidance/ng56		✓
NICE Multiple sclerosis in adults: management [CG186] 2019 https://www.nice.org.uk/guidance/cg186	✓	
NICE Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management [NG206] 2021 https://www.nice.org.uk/guidance/ng206	✓	✓
The National Service Framework for Long-term Conditions 2005 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198114/National_Service_Framework_for_Long_Term_Conditions.pdf	✓	✓
NHS RightCare Community Rehabilitation toolkit 2020 https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2020/03/nhs-rightcare-community-rehab-toolkit-v12.pdf		
NICE Older people with social care needs and multiple long-term conditions [NG22] https://www.nice.org.uk/guidance/ng22	✓	✓
NICE Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138] 2020 https://www.nice.org.uk/guidance/cg138		✓
NICE People's experience in adult social care services: improving the experience of care and support for people using adult social care services [NG86] 2018 https://www.nice.org.uk/guidance/ng86		✓
NICE Rehabilitation after traumatic injury [NG211] 2022 https://www.nice.org.uk/guidance/ng211	✓	✓
Commissioning Guidance for Rehabilitation 2017 https://www.england.nhs.uk/wp-content/uploads/2016/04/rehabilitation-comms-guid-16-17.pdf		✓
NHS England, South Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders 2014 https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf	✓	✓

NICE Shared decision making [NG197] 2021 https://www.nice.org.uk/guidance/ng197		✓
NICE Stroke rehabilitation in adults [CG162] 2013 https://www.nice.org.uk/guidance/cg162	✓	✓
NICE Supporting adult carers [NG150] 2020 https://www.nice.org.uk/guidance/ng150	✓	✓
NICE Transition between inpatient hospital settings and community or care home settings for adults with social care needs [NG27] https://www.nice.org.uk/guidance/ng27	✓	✓

ERG Commentary

— The role of both formal and informal carers is important and must be recognised

— The tension between engaging families and expecting families to support rehabilitation is recognised

Appendix 4 — Audit Tools

Audit tools for patients

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

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

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

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

Audit tools for clinicians

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

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

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

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

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

Audit tool for Service/Rehabilitation Lead

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

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

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

I identify service priorities and link, collate and review data to these	
I ensure staff are aware of the data analysis and how this feeds into service design	
I ensure that the information system is appropriate and sufficient to gather and review information on rehabilitation services to monitor quality and outcomes	PROMS, PREMS, patient goals and service activity
I support a learning culture around compliments, complaints, adverse incidents and SUIs	Staff survey
Adequate Treatment Programme	
I have the budget to ensure adequate staff numbers, and expertise to deliver timely and effective treatment	Annual report
I deliver and monitor mandatory face to face training in supported self-management	Family surveys.

Appendix 5 — Directors Annual Report

The Directors Annual report should include:

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

The patients and their family, friends and carers

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

The clinicians

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

The network

1. Account of network structure and work streams